

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01778 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maple Lane Nursing Home

How long in hospital or institution?

9 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 10000 Beech's Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

FANNIE ADES

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Harry Ades

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 18818. AGE: Years Months Days If less than one day  
67 — — — hrs. min.9. Birthplace Russia  
(Town, county, and state)10. Usual occupation house-wife

11. Industry or business

12. Name Loeb Levine13. Birthplace Russia14. Maiden name Toby15. Birthplace Russia16. Informant Sig AdesAddress 9700 Marshall Ave, Silver Spring, Md17. Burial Date thereof Feb. 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore Hebrew CemeteryLocation Baltimore, Md.18. Funeral director Benard H. Hays, 1400 N. 1st St.Address 3501-14 3rd St. Wash. D.C.19. Feb 19 1948 Joseph W. Schoeff  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947, to Feb. 19 1948  
and that I last saw him alive on Feb. 19 1948

Immediate cause of death

Acute intestinal obstruction

DURATION

Due to

Chronic debility

Due to

Other conditions Cerebral hemorrhage with left hemiplegia  
(Include pregnancy within 8 months of death)

Major findings of operations

none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Henry M. Lowden M.D.  
Address 1603 19th St. N.W. Date signed 2/19/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

RECEIVED  
FEB 21 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Eight years  
 Hospital, institution, or street address where death occurred:  
514 Green Wood Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 514 Green Wood Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Margaret Louisa Agnew

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

John Smith Agnew

## 7. Birth date of deceased (mo., day, yr.)

December 14, 1858

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

89122

hrs.

min.

## 9. Birthplace

Emmitsburg, Maryland  
(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

Home

## FATHER

## 12. Name

Eli Horner

## 13. Birthplace

## MOTHER

## 14. Maiden name

Sophia Agnew

## 15. Birthplace

## 16. Informant

Mrs. Dorothy Rife

## Address

514 Green Wood Ave, Tak. PK, Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Feb 7 48  
(month) (day) (year)

## Cemetery or burying place

EMMITSBURG Cem.

## Location

EMMITSBURG, MD.

## 18. Funeral director

## Address

W.H. Rife & Co  
3501 14th St. N.W. Washington, D.C.

## 19.

Feb 5 48  
(Date rec'd by registrar)

19. 48

John RifeRegistrarRegistrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1948 at 12:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15, 1947 to Feb. 4, 1948and that I last saw him/her alive on February 4, 1948Immediate cause of death Cardio-vascularrenal disease withgeneralized anasarcaArteriosclerosis, gen-eralized andHypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wallace Z. Mook M.D.805 Carroll Ave.Takoma Park, Md

Address

Date signed 2-5-48

RECEIVED  
FEB 6 1948  
RUSSELL



Evidence for Change  
of year of birth shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 114 FEB 27 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 01780 Y14

1. PLACE OF DEATH:  
County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months  
Hospital, institution, or street address where death occurred:  
505 Schuyler Road  
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 505 Schuyler Road  
(If rural, give LOCATION)  
None  
2.(a) If veteran, name war

3.(a) FULL NAME  
Lucy Williams Allnutt

3.(b) Social Security Number  
None

4. Sex Female  
5. Color or race White  
6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Joseph N. Allnutt  
6.(c) If alive, give age 85 years  
7. Birth date of deceased (mo., day, yr.) February 15, 1871 1869  
8. AGE: Years 77 Months 78 Days 11 If less than one day  
12 hrs. 12 min.

9. Birthplace Poolesville, Maryland  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business None  
12. Name Walter Allnutt  
13. Birthplace Maryland  
14. Maiden name Hester Chiswell  
15. Birthplace Maryland

16. Informant Mrs. Lawrence Whittacher  
Address Silver Spring, Maryland  
17. Burial February 9/48  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or crematory Monocacy Cemetery  
Location Bellsville, Maryland  
18. Funeral director Wm. Lawrence Company  
Address Bethesda, Maryland

19. Feb. 9 19 48 Joseph N. Schreff  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1948 19 48 at 9:24A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct. 1946 to 2/7 19 48  
and that I last saw him 2/7 alive on 2/7 19 48

Immediate cause of death  
Peritonitis  
Due to Empyema of gall bladder  
Due to Carcinoma of gall bladder + bile duct  
Other conditions

DURATION  
2 weeks  
2 weeks  
2-3 yrs.

(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE James F. Burns, M.D.  
1835 T St. N.W.  
M. D. or other  
Address 2/7/48  
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 12 1948  
BUREAU V A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months, 1 day  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 months, 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Colorado County \_\_\_\_\_  
City or town Colorado Springs  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

ANGLIN, Norma Stevens

### 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Hugh W. Anglin  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) October 10, 1921  
8. AGE: Years 26 Months 4 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Col.  
(Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business \_\_\_\_\_  
FATHER 12. Name STEVENS, Frank dec. \_\_\_\_\_  
13. Birthplace Mass.  
MOTHER 14. Maiden name SULLIVAN, Irene  
15. Birthplace Idaho

18. Informant husband: Lt. (JG.) Hugh W. Anglin, USN  
Address 3000 Lee Highway, Arlington, Va.  
17. (burial) Removal Date thereof Feb 27, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory \_\_\_\_\_  
Location Colorado Springs, Col.  
18. Funeral director S. H. HINES, JAC.  
Address 2901 14th St., N.W., Wash. D.C.  
Mary C. Patterson  
2-27 48  
19. (Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 27 February 19 48 at 9:15AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 December 19 47 to 27 Feb. 19 48  
and that I last saw h. or alive on 27 Feb. 19 48  
Immediate cause of death Bronchiectasis far Advanced  
Left Lung. DURATION Months 6-8  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Multiple Abscesses Left Lobe Months 6-8  
SHOCK - Prob. Spoke 20 hrs  
(Include pregnancy within 3 months of death)  
Major findings of operations Bronchiectasis 8 multiple  
abscesses Left Lung Date of op. 2-26-48  
Autopsy results Bronchiectasis far Advanced Multiple Abscesses  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
R. N. Shelley  
R. N. SHELLEY, Capt. MC USN  
23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 2-27-48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

01782

214

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....MontgomeryCity or town.....Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

RURAL RESIDENCE or street address where death occurred:

607 McNeill Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....MontgomeryCity or town.....Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No.....607 McNeill Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MRS. MARGARET ARNETT

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband ~~or wife~~.....James M.

## 7. Birth date of

deceased (mo., day, yr.)

July 18th. 1872

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

7579

hrs.

min.

9. Birthplace.....Kentucky  
(town, county, and state)10. Usual occupation.....Retired

## 11. Industry or business

FATHER  
MOTHER12. Name.....Charles Patrick13. Birthplace.....Kentucky14. Maiden name.....(Elizabeth) Margaret Patrick15. Birthplace.....Kentucky16. Informant.....Mrs. Layman VanW KnightAddress.....607 McNeill Rd. Silver Spring17. Removal & Burial Date thereof.....2-28-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or place of burial.....Lee CityLocation.....Wolfe Co. Kentucky18. Funeral director.....Charles E. Humphrey, Jr.Address.....Silver Spring, Md.19. Feb 27 19 48 James M. Schaefer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 27 19 48 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 10 19 42 to Feb. 27 19 48  
and that I last saw him alive on Feb. 27 19 48

Immediate cause of death.....

Cerebral cardiac infarction

DURATION

10 minDue to.....generalized Arteriosclerosis6 years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

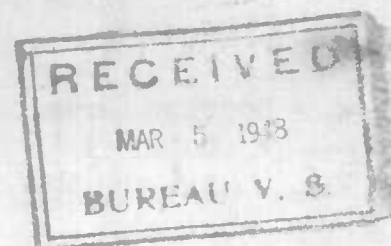
23. SIGNATURE.....W. B. Waidrop, M.D.  
M. D. or otherAddress.....943 Bonaparte St.  
Silver Spring, Md. Date signed.....2/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery Co.City or town North Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Years

Hospital, institution, or street address where death occurred:

Conn. Ave. Near Jones Bridge Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9504 Jones Mill Road,

(If rural, give LOCATION)

None

2.(a) If veteran, name war

## 3. (a) FULL NAME

Wallace B. Arthur

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary Ellen Arthur

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

August 22, 1874

## 8. AGE:

Years

Months

Days

If less than one day

737364

.....hrs.

.....min.

9. Birthplace Irdell Co., North Carolina  
(Town, county, and state)10. Usual occupation Handyman

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Amos Arthur

## 13. Birthplace

North Carolina

## 14. Maiden name

Mary Pyller

## 15. Birthplace

North Carolina16. Informant Mrs. Wilma Stoupe

## Address

Dallas, North Carolina17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof April 22, 1948

(month) (day) (year)

Cemetery or crematory Cedar Hill CrematoryLocation Prince George Co, Washington, D.C

## 18. Funeral director

W. E. Kuhn  
Bethesda, Maryland

## 19.

4/22/48  
(Date rec'd by registrar)W. E. Kuhn  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Unknown

19

at

M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Defunct State Case

and that I last saw him

alive on

19

## Immediate cause of death

Unknown

## CAUSATION

## Due to

Natural causes

## Due to

Body found in bush along road of Jones Bridge Rd Chevy Chase.

## Other conditions

Body badly decomposed  
(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Frank J. Brosschard M.D.  
Defunct State Case  
Gaithersburg Md

M. D. or other

Address

Date signed 4-24-48



312

RECEIVED  
APR 29 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

01783

95c

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### 1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:  
10316 Old Bladensburg Rd.  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.  
City or town Silver Spring Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 10316 Old Bladensburg Rd.  
(If rural give LOCATION)  
no  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

George Howard Bean

### 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Mary Jane

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Mar. 6th. 1864

8. AGE: Years 83 Months 11 Days 21 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name John Bean

13. Birthplace Maryland

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_

16. Informant Mr. Harry Bean (son)

Address 10316 Old Bladensburg Rd.

17. Burial Date thereof 3/1/1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Colesville Church

Location Colesville, Montg. Co. Md.

18. Funeral director Walter E. Humphrey

Address Silver Spring, Md.

19. Feb 29 1948 Josephine Schaeff  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb. 1948 at 11:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946 1946 to 27 Feb 1948  
and that I last saw him alive on 27 Feb 1948

Immediate cause of death Cerebral embolus DURATION 5 days

Due to auricular fibrillation 6-8 yrs

Due to \_\_\_\_\_

Other conditions Cardiac decompensation

(Include pregnancy within 8 months of death)

Major findings: \_\_\_\_\_

Di operations \_\_\_\_\_

Di autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William D. Culp MD M. D. or other \_\_\_\_\_

Address Silver Spring, Md. Date signed 27 Feb 48

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

MAR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

01784

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hedgecroft Park

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Hedgecroft Park  
(If rural, give LOCATION)

2.(a) If veteran, name was

## 3. (a) FULL NAME

Waldo E. Bennett

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife

Ottie Bennett

7. Birth date of

deceased (mo., day, yr.)

Apr 20 18696. (c) If alive, give age 64 years

8. AGE:

Years

Months

Days

If less than one day

78106

hrs.

min.

9. Birthplace

W. Va  
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

MOTHER FATHER

12. Name

Oliver Bennett

13. Birthplace

W. Va

14. Maiden name

Mary Haddet

15. Birthplace

W. Va

16. Informant

Ottie Bennett

Address

Silver Spring Md

17. BURIAL

(Burial, cremation, or removal: Which?)

Date thereof

FEB 28 - 1948  
(month) (day) (year)Cemetery or crematory FORT LINCOLN

Location

PRINCE GEORGES CO. MARYLAND

18. Funeral director

Warner E. Humphrey, Inc.

Address

SILVER SPRING - MD

19.

(Date rec'd by registrar)

19.

48 Joseph Schaeffe  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 26 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam Case 1948 to 1948and that I last saw h. alive on Feb 26 1948

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

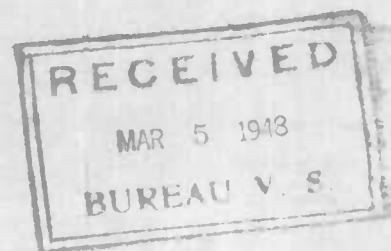
23. SIGNATURE

Frank J. Brothart M.D.

M. D. or other

Address

Silver Spring MdDate signed 2-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01785

Reg. Dist. No. 414

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

915 Philadelphia Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 915 Philadelphia Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

SUSIE E. BERRY

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband ~~xxx~~ George Berry

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

August 11, 1857

8. AGE:

Years

Months

Days

If less than one day

9061

hrs.

min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

MOTHER FATHER

12. Name Unknown13. Birthplace Virginia14. Maiden name Unknown15. Birthplace Unknown16. Informant William H. Berry, sonAddress 915 Phila. Ave., Silver Spring, Md.17. Burial Date thereof Feb. 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery ~~xxxxxx~~ Cedar Hill CemeteryLocation Suitland, Pr. Geo. Co., Md.18. Funeral director Warner E. HumphreyAddress 8434 Ga. Ave., Silver Spring, Md.19. Feb-13 19 48 James M. Schaeffer  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 19 48 at 1230 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 13 19 47, to Feb 12 19 48and that I last saw her alive on Feb 11 19 48Immediate cause of death Generalized arteriosclerosis

DURATION

yes -Due to Generalized arteriosclerosisyes -Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry J. Kearns M.D.

M. D. or other

Address 608 Forest Blvd Date signed Feb 12 1948





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01786

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 years  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery  
City or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4611 De Russay Parkway  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

MRS. MARTHA ELIZABETH BOLT

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6.(b) Name of husband or wife

Montreville T. Bolt

7. Birth date of deceased (mo., day, yr.) 8.(c) If alive, give age years

October 17 1860

8. AGE: Years Months Days If less than one day

87 3 26 hrs. min.

9. Birthplace (Town, county, and state)

Smith County Virginia

10. Usual occupation

Housewife

11. Industry or business

12. Name 13. Birthplace

George Kegley Virginia

14. Maiden name 15. Birthplace

JANE MUSSER Virginia

18. Informant Address

MR. WALTON M. MAY  
4611 De Russay Pkwy.

17. Burial (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Feb. 16, 1948

Cemetery or crematory Location

Ft. Lincoln Cemetery  
Washington, D.C.

18. Funeral director Address

S. W. Miller Co.  
2901-14th Street N.W. Washington, D.C.

19. (Date rec'd by registrar)

2/13 48 Jm E Jones Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 48 at 3:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 47 to Feb. 13 19 48 and that I last saw him alive on Feb. 12 19 48

Immediate cause of death PNEUMONIA, Bronchial DURATION ONE DAY

Due to ARTERIOSCLEROTIC, CARDIO VASCULAR DISEASE YEARS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. E. DeLawter M.D. M. D. or other

Address 7345 Wisconsin Ave Bethesda, Md. Date signed 2-13-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01787  
296

1. PLACE OF DEATH:

County MONTGOMERY  
City or town CHEY CHASE, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MARYLAND County MONTGOMERY  
City or town CHEY CHASE  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4608 LANGDRUM LANE  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS MARY LOCKWOOD BROWNE

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

GEN. FREDERICK W. BROWNE

6.(c) If alive, give age years

7. Birth date of  
deceased (mo., day, yr.)

OCT 16, 1877

8. AGE:

Years

70

Months

3

Days

18

If less than one day

hrs. min.

9. Birthplace

AIKEN SO. CAROLINA

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

FATHER

12. Name

PAUL LOCKWOOD

13. Birthplace

SO. CAROLINA

MOTHER

14. Maiden name

JEAN BORG

15. Birthplace

SO. CAROLINA

16. Informant

GEN. FREDERICK BROWNE

Address

4608 LANGDRUM LANE, CH. CH.

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

Feb 11, 1948

Cemetery or crematory

Springfield, N. Va.

Location

Springfield, Virginia

18. Funeral director

Wm E Jones

Address

735 Tennessee Ave NW WASH. DC

19. (Date rec'd by registrar)

2/10/48

19. 48

Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 at 10:10 A.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from March 1 1945 to Feb 9 1948 and that I last saw him alive on Feb 8 1948

Immediate cause of death

Pneumonia (terminal)

DURATION

3 days

Due to

General atherosclerosis + hypertension

10 yrs

Due to

Myocardial infarction

2 yrs

Other conditions

Left sided hemiplegia

1 1/2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B. Rude M.D.

M. D. or other

Address

3900 Military Rd NW

Date signed 2/9/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01788

Reg. Dist. No. 213

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH:</b><br>County... <u>Montgomery</u><br>City or town... <u>Lincoln Park, Rockville, Md.</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>How long in above place of death?<br>Hospital, institution, or street address where death occurred:<br>How long in hospital or institution? |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>(If newborn infants give residence of mother)<br>State... <u>Maryland</u> County... <u>Montgomery</u><br>City or town... <u>Lincoln Park, Rockville, Md.</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>Street No. ....<br>(If rural, give LOCATION)<br>2. (a) If Veteran, name war.....  |  |
| <b>3. (a) FULL NAME</b><br><u>John Henry Campbell</u>   |  | <b>3. (b) Social Security Number</b><br>  |  |
| <b>MEDICAL CERTIFICATION</b>  |  |   |  |
| <b>4. Sex</b><br><u>Male</u>  |  | <b>5. Color or race</b><br><u>Colored</u>   |  |
| <b>6. (a) Single, married, widowed, or divorced</b><br><u>Married</u>   |  | <b>6. (b) Name of husband or wife</b><br><u>Eliza Campbell</u>  |  |
| <b>7. Birth date of deceased (mo., day, yr.)</b><br><u>March 10, 1878</u>   |  | <b>6. (c) If alive, give age</b> ..... years<br>If less than one day ..... hrs. .... min.   |  |
| <b>8. AGE:</b> Years <u>69</u> Months ..... Days ..... If less than one day ..... hrs. .... min.  |  | <b>9. Birthplace</b><br><u>Mt Zion, Md.</u><br>(City, town, county, and state)  |  |
| <b>10. Usual occupation</b><br><u>Laborer</u>   |  | <b>11. Industry or business</b><br>   |  |
| <b>12. Name</b><br><u>Charles Campbell</u>  |  | <b>13. Birthplace</b><br><u>Mt. Zion, Md.</u>   |  |
| <b>14. Maiden name</b><br><u>Matthia Joppiz</u>   |  | <b>15. Birthplace</b><br><u>Md.</u>   |  |
| <b>16. Informant</b><br><u>Eliza Campbell (wife)</u><br>Address <u>Lincoln Park, Rockville, Md.</u>   |  | <b>17. Burial</b><br>(Burial, cremation, or removal. Which?) Date thereof <u>Feb. 11, 1948</u><br>(month) (day) (year)<br>Cemetery or crematory <u>Lincoln Park, Rockville, Md.</u><br>Location <u>Robert L. Snowden</u><br>Address <u>Rockville, Md.</u>   |  |
| <b>18. Funeral director</b><br><u>Robert L. Snowden</u><br>Address <u>Rockville, Md.</u>  |  | <b>19. 2/11 1948</b><br>(Date rec'd by registrar) <u>EP Shoup</u> Registrar   |  |
| <b>20. DATE OF DEATH</b><br><u>Feb-8 1948</u> at <u>5P</u> M  |  | <b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b><br><u>Feb 8 1948</u> , to <u>Feb 8 1948</u><br>and that I last saw him alive on <u>Feb 8 1948</u><br>Immediate cause of death <u>Acute Nephritis</u><br>Due to <u>acute Nephritis</u><br>Due to <u>—</u><br>Other conditions <u>Chronic Nephritis</u><br>(Include pregnancy within 3 months of death)<br>Major findings of operations..... Date of op. ....<br>Autopsy results.....<br>PHYSICIAN: Please underline the cause to which death should be charged statistically. |  |
| <b>22. VIOLENCE: If death was due to external causes, fill in the following:</b><br>Accident, suicide, or homicide..... Date of .....<br>Where did injury occur? (City or town) (County) (State)<br>Injured at home, farm, industry, public place (where?)<br>Means of injury injured at work?  |  | <b>23. SIGNATURE</b><br><u>Matthia Joppiz</u> M. D. or other<br>Address <u>Rockville, Md.</u> Date signed <u>2/10/48</u>  |  |

RECEIVED  
FEB 12 1948  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

01789

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 35 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4621 N. Capital St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war PWI ✓

## 3. (a) FULL NAME

CARR, John William

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Anna M. Carr  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 20, 1888  
 8. AGE: Years 59 Months 2 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wash., D.C.  
 (Town, county, and state)  
 10. Usual occupation unknown  
 11. Industry or business \_\_\_\_\_  
 12. Name CARR, Joseph dec. \_\_\_\_\_  
 13. Birthplace Va.  
 14. Maiden name MURPHY, Mary dec. \_\_\_\_\_  
 15. Birthplace Ireland

16. Informant Wife: Mrs. Anna M. Carr  
 Address 4621 N. Capital St., N.W., Wash., D.C.  
 17. burial Date thereof 2-5-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director S. H. HINES W.A.S.  
 Address 2901 14th St., N.W., Wash., D.C.  
 19. 2-1 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 19 48 at 11:55A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 29 19 47, to Feb. 1 19 48  
 and that I last saw him alive on 2-1 19 48

Immediate cause of death Bronchopneumonia DURATION 4 da  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Adenocarcinoma of the  
rectum, a metastasis 2 1/2 yr  
 (Include pregnancy within 3 months of death)  
 Major findings of operation Adenocarcinoma  
of rectum Date of op. March '46  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE R. B. Webster JG MONUSN  
R. B. WEBSTER, Lt. M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 2-1-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

01730

83a

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### 1. PLACE OF DEATH:

County MONTGOMERY  
City or town ROCKVILLE  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: CHESTNUT LODGE SANITARIUM  
Stay in hospital or inst. (yrs., or mos., or days) 1 month 6 days  
Stay in this community (yrs., or mos., or days) 1 month 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY  
City or town SILVER SPRING Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 1308 Anson Street  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

CASSEDY, MILLER AIKEN

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE WIDOWED

B (b) Name of husband or wife MABEL CASSEDY

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1887

8. AGE: Years 60 Months 4 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace BOSTON, MASS  
(Town, county, and state)

10. Usual occupation CIVIL SERVICE

11. Industry or business DEPT. of Commerce

12. Name JOHN I. CASSEDY

13. Birthplace OHIO

14. Maiden name VESTA HARVEY

15. Birthplace OHIO

16. Informant VESTA H. CASSEDY, daughter

Address 1308 Anson St. Silver Spring

17. Burial Date thereof Feb. 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md.

18. Funeral director Wm. E. Humphrey

Address Silver Spring, Md.

19. 2/12 19 48 E. P. Thompson  
(Date rec'd by registrar) (In Signature)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10 FEBRUARY 19 48, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 JANUARY 19 48, to 10 FEBRUARY 19 48, and that I last saw him alive on 10 FEBRUARY 19 48.

Immediate cause of death BRONCHOPNEUMONIA, BILATERAL, RECURRENT DURATION 1 mon.

Due to CEREBRAL ACCIDENT, RIGHT TYPE, undetermined 1 WK

Due to CEREBRAL ARTERIO-SCLEROSIS 2

Other conditions SENILE DEMENTIA 2 mos

(Include pregnancy within 8 months of death)

Major findings: PHYSICIAN

Of operations \_\_\_\_\_ Please underline the cause to which death should be charged statistically.

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

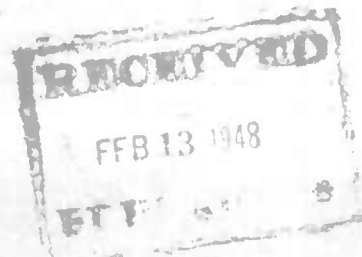
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert E. Humphrey MD M. D. or other

Address Chestnut Lodge Date signed 10 FEB  
Rockville 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

01791

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Laboria Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? seven weeks  
 Hospital, institution, or street address where death occurred:  
Washington San + Hospital  
 How long in hospital or institution? seven weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Montgomery  
 City or town Washington (D.C.)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1404 Park Rd. N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Helene Jeanne Clockner

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Charles Albert Clockner  
 7. Birth date of deceased (mo., day, yr.) May 24, 1889 8.(c) If alive, give age 57 years  
 8. AGE: Years 58 Months 8 Days 11 It less than one day hrs. min.

9. Birthplace Newchatel, Switzerland  
 (Town, county, and state)  
 10. Usual occupation Business woman  
 11. Industry or business Restaurant (now retired)  
 12. Name Fritz Widmer  
 13. Birthplace Newchatel, Switzerland  
 14. Maiden name unknown  
 15. Birthplace —

16. Informant Mr. Charles Clockner  
 Address 1404 Park Rd. N.W.  
 17. Cremation Date thereof Feb. 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln Cemetery  
 Location Washington D.C.  
 18. Funeral director S.H. Hines, Co.  
 Address 2901 14th St. N.W.  
 19. Feb 5 1948 John H. Hines Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948 1948 at 8:25 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4, 1947 to Feb. 5, 1948  
 and that I last saw him alive on Feb. 5, 1948

Immediate cause of death Periparturinary failure DURATION 2 days  
 Due to liver failure 1 month  
 Due to Carcinoma of rectum 1 yr.?  
 Other conditions —

(Include pregnancy within 8 months of death)  
 Major findings of operations Carcinoma of rectum  
Metastatic ca of liver Date of op. Dec 18, 1947  
 Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? — (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) —  
 Means of injury — Injured at work? —  
 23. SIGNATURE R. A. Quinn, M.D. M. D. or other —  
 Address Washington San + Hosp. Date signed 2/5/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01792

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)Now long in above place of death? 3 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 E. Underwood St.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Mayo Clay

## 3. (b) Social Security Number

none4. Sex Female5. Color or race Whiteb.(a) Single, married, widowed, or divorced MarriedB.(b) Name of husband or wife Roderick Odin ClayB.(c) If alive, give age 30 years7. Birth date of deceased (mo., day, yr.) Mar. 31 - 19168. AGE: Years 31 Months 10 Days 6 It less than one day

hrs. min.

9. Birthplace Augusta, Georgia  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Rudolph Sassone Mayo13. Birthplace Clay14. Maiden name Willie Bell15. Birthplace I. C.16. Informant Roderick O ClayAddress 100 E Underwood St.17. West View Cemetery Date thereof Feb 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Atlanta GaLocation Augusta, Georgia18. Funeral director George W. Mule, Jr.Address 2900 M St N.W. Washington DC19. 2/7 19 48 2pm E. E. E.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 19 48 at 11:55p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2 19 47 to Feb 6 19 48end that I last saw h. er alive on Feb 6 19 48

Immediate cause of death

Secondary aneurism

Due to non-pigmented melanoma involving left eyeDue to temporal region, left eye +at lung

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

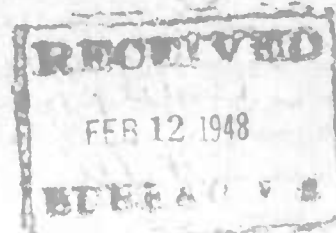
Means of injury Injured at work?

23. SIGNATURE S. W. Culver M.D.Address 3781 Chas St Date signed 2/7/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The Marrett age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

01793

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

21 years

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hosp., Takoma Park, 12, Md.

How long in hospital or institution?

20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Denwood Avenue  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3.(a) FULL NAME

Arthur Purdon Cook

## 3.(b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Ella A. Cook

7. Birth date of

deceased (mo., day, yr.)

December 13, 1860

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87

2

0

hrs.

min.

9. Birthplace

Geauga County, Chardon, Ohio  
(Town, county, and state)

10. Usual occupation

County Commissioner

11. Industry or business

Same

FATHER

12. Name

Alpheus Cook

13. Birthplace

Vermont

MOTHER

14. Maiden name

Laura Sanderson

15. Birthplace

Ohio

16. Informant

George A. Cook (son)

Address

22 Denwood Ave. Takoma Park, Md.

17.

(Burial, cremation, or removal. Which)

Date thereof

Feb. 16, 1948  
(month) (day) (year)

Cemetery or crematory

Geo. Wash. Memorial Cem.

Location

Riggs Rd. Hyattsville, Md.

18. Funeral director

Arthur J. Sanders

Address

254 Carroll St. Takoma Park, D.C.

19.

(Date rec'd by registrar)

Feb. 14, 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2-1319 48

at

3:40 P M

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

Jan. 23 19 48 to Feb. 13 19 48

and that I last saw him alive on

Feb. 13 19 48

Immediate cause of death

Cerebral heart failure

DURATION

1 day

Due to

Cerebral scientific heart disease

Due to

Other conditions

Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations

Benign prostatic hypertrophy

Date of op.

Feb. 6, 1948

Autopsy results

(As above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R.A. Dunn, M.D.

M. D. or other

Address

Washington San. & Hosp.

Date signed

Feb. 13, 1948

**RECEIVED**

FEB 18 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 273

01794

### 1. PLACE OF DEATH:

County.....*Montgomery*  
City or town.....*Rockville, Rural -*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....*LIFE -*  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....*None*

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....*MD* County.....*Mont*  
City or town.....*Rockville, Rural -*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....*Falls Road at Bell's Mill*  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....*None*

### 3. (a) FULL NAME

*Ada B. Cranford*

### 3. (b) Social Security Number

*None*

4. Sex.....*Female* 5. Color or race.....*white* 6.(a) Single, married, widowed, or divorced.....*widowed*  
6.(b) Name of husband or wife.....*Joseph H. Cranford*  
7. Birth date of deceased (mo., day, yr.).....*September 2, 1871*  
6.(c) If alive, give age..... years  
8. AGE: Years.....*76* Months.....*76* Days.....*5* If less than one day..... hrs. .... min.

9. Birthplace.....*Washington, D. C.*  
(Town, county, and state)  
10. Usual occupation.....*Housewife*  
11. Industry or business.....*None*  
12. Name.....*Joseph Twissowski*  
13. Birthplace.....*Poland*  
14. Maiden name.....*Ada Bassett*  
15. Birthplace.....*Washington, D. C.*

16. Informant.....*Henry S. Cranford*  
Address.....*Rockville, Maryland*  
17. Burial.....*March 1, 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory.....*Rock Creek Cemetery*  
Location.....*Washington, D. C.*  
18. Funeral director.....*Wm. Luman Rumpsey*  
Address.....*Bethesda, Maryland*  
19. *3-1* 19 *48* *E.P. Thompson*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....*3/26* 19 *48* at *2:15 P*  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *2/30* 19 *48* to *3/26* 19 *48*  
and that I last saw h..... alive on *2/25* 19 *48*  
Immediate cause of death.....*URemia -*  
Due to.....*Hypertensive cardio-renal disease -*  
Due to.....*Hypertension*  
Other conditions.....*congestive heart failure -*  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... injured at work?  
23. SIGNATURE.....*with seal 20.*  
Address.....*Rockville* M. D. or other.....  
Date signed *3/26/48*

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 4 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01795-223-

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park, Maryland  
Since 1942 (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death 28 days  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
How long in hospital or institution? 28 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 602 Garland Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mrs Mae Andre Cummins

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife deceased

7. Birth date of deceased (mo., day, yr.) May 1, 1874 6.(c) If alive, give age years

8. AGE: Years 73 Months 9 Days 6 If less than one day hrs. min.

9. Birthplace Franklin Furnace, Ohio  
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Claudius Andre

13. Birthplace Unknown

14. Maiden name May Jane Lamb

15. Birthplace Unknown

16. Informant Mrs Corwin C. Cummins

Address 1521 W. 10th St. Anderson Indiana

17. Burial Date thereof Feb. 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Brownwood Cemetery

Location Hinsdale Illinois

18. Funeral director J. Arthur Walters

Address 234 Carroll St. NW. Takoma Park, DC

19. Feb 8 19 48  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1948 at 8:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Feb 7, 1948 and that I last saw her alive on Feb 7, 1948

Immediate cause of death Coronary Cardiac Failure DURATION terminal

Due to Hypertension years

Due to Cerebral Hemorrhage 2 1/2 wks

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare MD. M. D. or other

Address Takoma Park, Md. Date signed 2/7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 1-21-48Hospital, institution, or street address where death occurred: Suburban Hosp.8000 Old Georgetown Rd. Bethesda - Md.How long in hospital or institution? Since 1-21-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State R.R. #2 Md. County MontgomeryCity or town German town Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.R. #2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr Armistead P. Curtis4. Sex m 5. Color or race w 6. (a) Single, married, widowed, divorced6.(b) Name of husband or wife Pauline Curtis7. Birth date of deceased (mo., day, yr.) March 23, 1908 8. (c) If alive, give age 35 years8. AGE: Years 39 Months 10 Days 12 If less than one day  
hrs. min.9. Birthplace Seneca Md.  
(Town, county, and state)10. Usual occupation Chauffeur11. Industry or business Naval Ordinance12. Name John W. Curtis13. Birthplace Fredericksburg Virginia14. Maiden name Carrie Maxley15. Birthplace Fredericksburg Virginia18. Informant Mrs Armistead CurtisAddress German town Md17. Burial Date thereof 2/8/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory PresbyterianLocation Barnes town Md18. Funeral director William B. HiltonAddress Barnesville, Md18. Feb. 7 1948 Wm E Jones  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

214-03-6285

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 19 48 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dr - 19 47 to Feb - 5 - 1948  
and that I last saw him alive on Feb - 5 - 1948Immediate cause of death Dissemination of liver (Carcinoma) DURATION 2 mos

Due to

Due to

Due to

Other conditions Pulmonary Thrombosis 48 hrs  
1. Sepsis originating 48 hrs  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

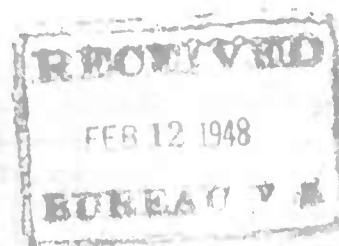
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Jones M. D. or otherAddress Garthursburg, Md Date signed





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: **MONT.**  
 County.....  
 City or town..... **CHEVY CHASE**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **MARYLAND** County..... **MON.T.**  
 City or town..... **CHEVY CHASE**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **6969 BROOKVILLE ROAD**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
**DR NELSON H. DARTON**

3. (b) Social Security Number  
**NONE**

4. Sex **M** 5. Color or race **W.** 6. (a) Single, married, widowed, or divorced

6. (b) Name of **WIFE** **ALICE DARTON**

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) **DEC. 17, 1865**

8. AGE: Years **82** Months **2** Days **11** If less than one day  
 .... hrs. .... min.

9. Birthplace **BROOKLYN, NEW YORK**  
 (Town, county, and state)

10. Usual occupation **GEOLOGIST - U.S. GOVERNMENT**

11. Industry or business

12. Name **William Darton**

13. Birthplace **Boston, Mass.**

14. Maiden name **Caroline Thayer**

15. Birthplace **New York, N.Y.**

16. Informant **Alice W. Darton**

Address **6969 Brookville Rd**

17. **BURIAL** Date thereof **MARCH 1, 1948**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory **MOUNT OLIVET**

Location **WASHINGTON, D.C.**

16. Funeral director **Jas. Sawley Sons**

Address **1756 Pa. Ave. N.W. WASH. D.C.**

19. **2/29/48** **JPM E Jones**  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **Feb. 28, 1948** 19 **12:20 a.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March 15, 1946** to **Feb. 28, 1948**  
 and that I last saw him alive on **Feb. 26, 1948**

Immediate cause of death **chronic myocarditis** DURATION **2 yrs**

Due to **Generalized arterio-sclerosis** **10 yrs.**

Due to **severe**

Other conditions **Married pulmonary fibrosis (old white)**

Major findings of operations.....

Anteopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **George Sawyer M.D.**

Address **1629 Col. Rd. NW WASH. D.C.** Date signed **2/28/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01798

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

At home - 4707 Chase AvenueHow long in hospital or institution? At home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4707 Chase Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

CLYDE V. DE BINDER

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Freda Clayton DeBinder7. Birth date of deceased (mo., day, yr.) January 12, 1890 6.(c) If alive, give age 57 years8. AGE: Years 58 Months 1 Days 2 If less than one day  
..... hrs. .... min.9. Birthplace Philadelphia, Pennsylvania  
(Town, county, and state)10. Usual occupation Bureau of Printing & Engraving11. Industry or business U.S. Government12. Name Samuel DeBinder, Sr.13. Birthplace Pennsylvania14. Maiden name Catherine Hartline15. Birthplace Pennsylvania16. Informant Freda C. DeBinderAddress 4707 Chase Ave., Bethesda, Md.17. Burial Date thereof Feb. 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ft. Lincoln CemeteryLocation Washington, D.C.18. Funeral director Wm. E. JonesAddress 7557 Wisconsin Ave., Bethesda, Md.19. 2/16/48 Registrar Wm E Jones

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1948 at 12:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13th 1948 to Feb. 14th 1948and that I last saw him alive on February 14, 1948Immediate cause of death Coronary occlusion(Coronary occlusion) 24 hoursDue to Unknown causesDue to Unknown causesOther conditions Unknown causes

(Include pregnancy within 3 months of death)

Major findings of operations Unknown causesDate of op. Unknown causesAutopsy results Unknown causes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Unknown causes Date of Unknown causes

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Unknown causes Injured at work?Signature Wheeler O. Huff - M.D. M. D. or otherAddress 7701 Wisconsin Ave., Bethesda, Md. Date signed 2-15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12823 01799 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 6 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town  Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 302 Lund Drive  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Russell T. Edwards

## 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

8. (b) Name of husband or wife Benita Parker Edwards

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1878-

8. AGE: Years 69 Months 5 Days 8 It less than one day dec. years

9. Birthplace Brigdon, Ontario, Canada

10. Usual occupation Retired

11. Industry or business

12. Name Wm G. Edwards

13. Birthplace Wales

14. Maiden name Martha Bridge

15. Birthplace Wales

16. Informant Burke Edwards (son)

Address same

17. Burial National Memorial Park

(Burial, cremation, or removal. Which?) Date thereof Feb. 6, 1948

Cemetery or crematory ARLINGTON, Virginia

Location Bethesda, Maryland

18. Funeral director Wm. Landon Humphrey

Address Bethesda, Maryland

19. Feb. 6 19 48

(Date rec'd by registrar) Wm E Jones Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-3, 19 48 at 8:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9, 19 47, to Feb. 3, 1948

and that I last saw him alive on 3 Feb. 1948.

Immediate cause of death Pneumonia, Complicated

Relieved with large amount

Paranecephalic

Due to Pneumothorax, Right upper

Partial

Due to Internal Hydrocephalus Chronic

13 weeks

Other conditions Pericarditis Hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. Ball M.D.

Address 79 S. Georgetown Rd. Bethesda, Md.

Date signed 4 Feb. 48

DURATION  
3 days





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Birth -  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital - Old Geo. Rd.  
 How long in hospital or institution? Birth

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State DC County DC  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 625 Monroe St. N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3.(a) FULL NAME

John Samuel Flemings

## 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White —

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 28-1948

8. AGE: Years Months Days If less than one day  
 1 4 hrs. 1 min.

9. Birthplace Suburban Hospital Bethesda Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name SAMUEL FRANKLIN FLEMINGS

13. Birthplace Harpers Ferry, West Virginia

14. Maiden name Lillian Mary Nelson

15. Birthplace New York City, New York

16. Informant Samuel Franklin Flemings

Address 625 Monroe St. N.E. Wash. DC

17. Date thereof March 1 1948

(Burial, cremation, or removal. Which?)

Cremation Suburban Hospital

Cemetery or crematory Bethesda Md.

Location

18. Funeral director A.B. Salomon /suph

Address Bethesda 14. Md.

19. 3/6/48 7pm E. Jones Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 29 1948 at 5:10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 1948 to Jan 28 1948

and that I last saw him alive on Jan 28 1948

Immediate cause of death

Dementia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 5016 1/2 St. N.E. Date signed 2/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01801

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Georgetown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Damascus  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Alice Foreman

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Col. Married6. (b) Name of husband or wife Westley Foreman7. Birth date of deceased (mo., day, yr.) March 17, 1894 6. (c) If alive, give age years8. AGE: Years Months Days if less than one day  
53 10 27 hrs. min.9. Birthplace Montgomery County, Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name George Carroll  
13. Birthplace Montgomery County, Md.14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital record

Address

17. Burial Date thereof Feb 17, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory John WesleyLocation Rocky Hill Bur.18. Funeral director Rayon BarberAddress Laytonville Md19. Feb 17 19 48 Bertine B Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 19 48 at 11:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 19 48, to February 14 19 48, and that I last saw her alive on February 14 19 48.

Immediate cause of death

Unarmed

DURATION

10 daysDue to Chronic IntestinalDue to Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE MB 1 M. D. or otherAddress Sandy Spring, Md Date signed 2/15/48

RECEIVED

MAR 12 1948

BUREAU V. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21802 2/6

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

4819 St. Elmo Avenue.How long in hospital or institution? None2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4819 St. Elmo Avenue

(If rural, give LOCATION)

None

2. (u) If veteran, name war

## 3. (a) FULL NAME

Mathilda Elizabeth Fulks

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife John S. Fulks

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1888

## 8. AGE:

59

Years

Months

7

Days

5

If less than one day

hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Max Felka13. Birthplace South Africa14. Maiden name Amelia Lang15. Birthplace Baltimore, Maryland16. Informant Joseph SchwartzAddress 1817 18th St. S. E.17. Burial Date thereof February 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest Oak CemeteryLocation Gaithersburg, Maryland18. Funeral director Wm. R. Ransom, Inc.Address Bethesda, Maryland19. 218 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1948 at 3:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 5, 1948 to February 6, 1948  
and that I last saw him live on February 6, 1948Immediate cause of death Cerebral hemorrhage 24 hoursArterio-sclerosis - UnknownDue to Chronic Nephritis Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

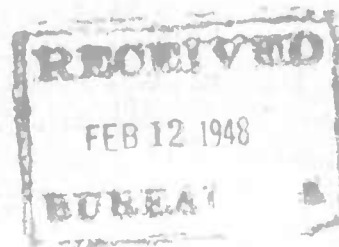
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wheeler D. Huff M.D.Address Bethesda, Md. Date signed 2-7-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

01803

216

## 1. PLACE OF DEATH:

Country Montgomery  
 City or town Potomac  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred:

None

How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Ashton  
(If outside city or town limits, write RURAL and give nearest town)Street No. None  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mordecai Taylor Fussell

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Isabelle Blair Fussell6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) June 11, 1852

8. AGE: Years 95 Months 95 Days 8 If less than one day 15 hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Fussells Ice Cream Co.12. Name Jacob Fussell13. Birthplace Hardford County, Maryland14. Maiden name Amie Elizabeth Taylor15. Birthplace Unknown16. Informant Mr. Norris FussellAddress Ashton, Maryland17. Burial Green Mount Cemetery Date thereof Feb. 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore, MarylandLocation Bethesda, Maryland18. Funeral director Wm. E. JonesAddress Bethesda, Maryland19. Feb. 28, 48 Wm E Jones  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Feb 1948 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Feb 1948 to 26 Feb 1948 and that I last saw him alive on 25 Feb 48 1948

Immediate cause of death Coronary Occlusion DURATION 5 Minutes

Due to Coronary Arteriosclerosis 5 yrs

Due to Arteriosclerosis 20 yrs

Other conditions Cellulitis bed sores 2 months

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE W S Murphy MD M. D. or otherAddress Rochville Md Date signed 26 Feb 48



RECEIVED

MAR 3 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County.....Montgomery  
City or town.....Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....34 hrs 35 min  
Hospital, institution, or street address where death occurred:  
Washington San. Hosp.  
How long in hospital or institution?.....34 hrs 25 min

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....md. County.....Montgomery  
City or town.....Box 492 Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....Box 492  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Gregory, Mr. George Wilson

### 3. (b) Social Security Number

4. Sex.....M 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....widower

6.(b) Name of husband or wife.....ELLA MCINTYRE  
Dec. 25, 1869 6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years.....78 Months.....2 Days.....0 If less than one day..... hrs. .... min.

9. Birthplace.....Bath N.Y.  
(Town, county, and state)

10. Usual occupation.....Retired

11. Industry or business

12. Name.....Gregory, Charles

13. Birthplace.....Bath, N.Y.

14. Maiden name.....Hawkins, Jane

15. Birthplace.....?

16. Informant.....MRS. E. E. MCINTYRE

Address.....Box 492 - SILVER SPRING - MD.

17. Burial: Date thereof.....Feb - 27 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....GRACE CHURCH CEMETERY

Location.....WOODSIDE - MONTG. CO. MARYLAND

18. Funeral director.....James E. Dunphy

Address.....SILVER SPRING - MD.

19. Date rec'd by registrar.....Feb. 26, 1948

Registrar.....[Signature]

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....2 - 25 1948, at.....6:39 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Aug 12 1947 to.....2-25 1948  
and that I last saw him alive on.....2-24 1948

Immediate cause of death.....Bronchopneumonia  
Due to.....Arteriosclerotic Heart Disease & Decompensation  
Due to.....  
Other conditions.....  
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Dean H. Harding MD  
Address.....113 Carroll St NW Date signed.....2-25-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01804

93d

RECEIVED  
FEB 28 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County Montgomery  
 City or town near Rockville and  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Montgomery  
 City or town near Rockville and  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Beantown  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Green

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male all widowed

6. (b) Name of husband or wife 6. (c) If alive, give age years

Lilly Green

7. Birth date of deceased (mo., day, yr.) June 22 1957

8. AGE: Years 19 Months 8 Days 8 If less than one day  
 hrs. min.

9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Labour

11. Industry or business

FATHER 12. Name Unknown  
 13. Birthplace

MOTHER 14. Maiden name Unknown  
 15. Birthplace

16. Informant Harry Green (son)  
 Address Rockville, Ind.

17. Burial Date thereof March 2, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lincoln Park  
Rockville, Maryland  
 Location

18. Funeral director R. L. Snowden  
 Address Rockville, Maryland

19. 3-2 19 48 S. Thompson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 19 48 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 1946 19 48 to Feb 22 19 48  
 and that I last saw him alive on Feb 29 19 48

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions Arterio Sclerosis  
Chronic Nephritis  
 (Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Hawks M. D. or other

Address Rockville Ind Date signed 3/2/48

RECEIVED

MAR 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 hrs.

Hospital, institution, or street address where death occurred:

Washington Sen. & HospitalHow long in hospital or institution? 1 1/2 hrs.

## 3. (a) FULL NAME

Mrs. Catherine Greulich

## 4. Sex

Fe

## 5. Color or race

Cauc.

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Joseph E. Greulich7. Birth date of deceased (mo., day, yr.) Sept 12, 1904

6. (c) If alive, give age..... years

8. AGE: Years 43 Months 4 Days 27 If less than one day  
..... hrs. .... min.9. Birthplace Brooklyn, New York  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George Merweel13. Birthplace New York14. Maiden name Ida15. Birthplace New York16. Informant Mr. Joseph E. GreulichAddress 1013 Hopewell Ave. Tak. Pk. Md17. Burial Date thereof Feb. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Long - Park - Mem

Location

18. Funeral director J. Arthur WaltersAddress 254 Canaan St. NW. Takoma Park, DC19. Feb 10 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1013 Hopewell Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dip Med Exam Case

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

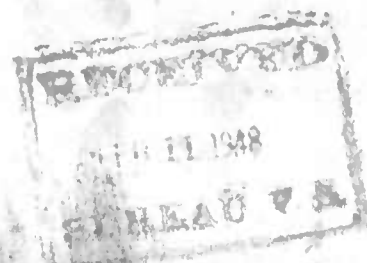
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, publc place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Frank J. Brochert M.D.Dip Med Exam M. D. or otherAddress Washington DC Date signed 2-9-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

01807

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Clarksburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Montgomery Co. Gen. Hosp.  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rockville (Countryside)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Nov 16 1947 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 2 Months 16 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Clarksburg, Md.  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Robt. Tringby13. Birthplace Va14. Maiden name Frances Eleanor15. Birthplace Va16. Informant Hosp. Records

Address \_\_\_\_\_

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 3 1948  
 (month) (day) (year)

Cemetery or crematory Family Burial LotLocation Greensville, Va. (unimproved)18. Funeral director Ray W. BarberAddress 20100 Millbrook Rd.19. Feb 3 19 48 Estimedes Lawler

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 48 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1st med exam case 19 \_\_\_\_\_, to 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

1st 2nd & 3rd degree burns 30 hrs.

involving jaw, head, and

Due to gasoline - (accident)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

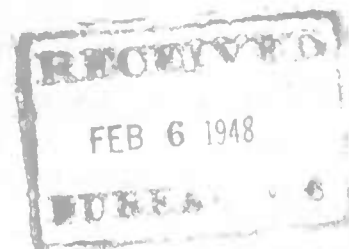
\_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-1-48Where did injury occur? Rockville R.F.D. Montgomery Md (County) (State)Injured at home, farm, industry, pub'l'c place (where?) HomeMeans of injury Home burned injured at work? no23. SIGNATURE Frank J. Broschart M.D.1st med exam M. D. or otherAddress Clarksburg Md Date signed 2-2-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01808 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 28 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 28 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County .....  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 527 Ingraham St., N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war Sp. Am. War ✓

### 3. (a) FULL NAME

GROSS, Clyde Ernest

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife .....  
6. (c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) March 4, 1878  
8. AGE: Year 69 Month 10 Day 29 If less than one day ..... hrs. .... min.

9. Birthplace Pa.  
(Town, county, and state)  
10. Usual occupation Retired Gov't. Employee  
11. Industry or business

12. Name unknown  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant daughter: Mrs. Esther M. Sheppard  
Address 527 Ingraham St., N.W., Wash., D.C.

17. burial Date thereof 2-6-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Arlington National  
Cemetery or crematory  
Location Arlington, Va.

18. Funeral director S. H. HINES H&A  
Address 2901 14th St., N.W., Wash., D.C.

19. 2-3- 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3 February 19 48 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
5 January 19 48, to 3 Feb. 19 48

and that I last saw him alive on ..... 19 .....

Immediate cause of death Bronchopneumonia DURATION

Due to .....

Due to .....

Other conditions Pneumatic Distention

(Include pregnancy within 3 months of death)

Major findings of operations confirmed

Autopsy results as above Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Manner of injury ..... Injured at work?

23. SIGNATURE P. L. BATES LT. JG MC USN

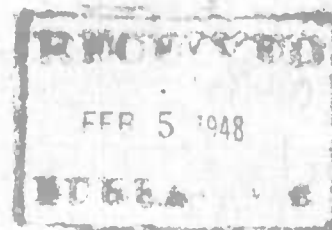
Address USNH Bethesda, Md. Date signed 2-3-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corrected page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County MoulbournCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6.5 years

Hospital, institution, or street address where death occurred:

R-7-D- Rockville Pike - Rockville

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MoulbournCity or town R-7-D Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rockville Pike R-7-D - Rockville  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

John Richard Harris

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mary Jane Harris6. (c) If alive, give age 88 years

## 7. Birth date of

deceased (mo., day, yr.)

March 5 - 1860

## 8. AGE:

Years

Months

Days

If less than one day

87118

hrs.

min.

## 9. Birthplace

Poloma - Moul Co - Md  
(Town, county, and state)

## 10. Usual occupation

Retired - Stone Mason

## 11. Industry or business

## MOTHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

## 19.

2/14/48

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

February 13, 1948, at 5 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 17, 1947, to Feb. 13, 1948

## and that I last saw him alive on

Feb. 10, 1948

## Immediate cause of death

acute dilatation of heartDue to chronic bronchitis

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

## Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

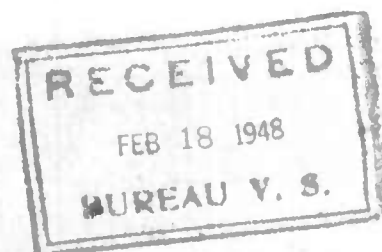
## 23. SIGNATURE

G. P. Hartley M.D.

M. D. or other

## Address

Rockville, MdDate signed 2/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH

County Montgomery  
 City or town Rockville Md R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery  
 City or town Rockville Md R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

William H. Hebron

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Bessie Hebron

## 7. Birth date of deceased (mo., day, yr.)

Sept. 9, 1870

## 6. (c) If alive, give age .....

## 8. AGE:

77

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Dawsonville, Md.  
Rebore

## 10. Usual occupation

## 11. Industry or business

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Feb. 12, 1948

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

2/11/48  
(Date rec'd by registrar)

19

EP Shoup

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1948, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 14 1947 to Feb 9 1948  
and that I last saw him alive on Feb 9 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

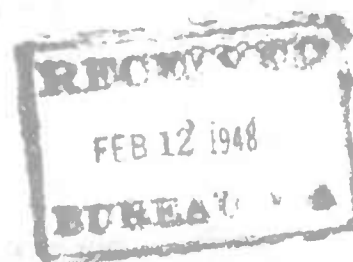
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed Feb 10/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01841 2161

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 9 hours  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 9 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3546 T St., N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI

### 3. (a) FULL NAME

HENDERSON, Herbert George

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced separated (10yrs)

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 14, 1894

8. AGE: Years 53 Months 5 Days 25 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation turck driver

### 11. Industry or business

12. Name HENDERSON, Roderick John

13. Birthplace Wash., D.C. dec.

14. Maiden name SAUL, Annie Marion

15. Birthplace 1<sup>st</sup> Md.

16. Informant Mother: Mrs. Annie M. Henderson

Address 3546 T St. N.W., Wash., D.C.

17. burial Date thereof 2-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS

Address Georgetown, D.C.

2-10 48 Mary C. Patterson

19. (Date rec'd by registrar) \_\_\_\_\_ Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 48 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 48 to 9 Feb. 48

and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Lobar pneumonia with flunza DURATION 6 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Frank J. Broschart M.D.

23. SIGNATURE Frank J. Broschart,

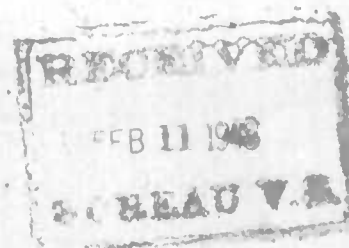
Deputy Medical Examiner M. D. or other

Address Gaithersburg, Md. Date signed 2-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District of Columbia County None  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6200 - 13th St. N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

HIGHTMAN, John Roy  
4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Eleanor M. Hightman  
7. Birth date of deceased (mo., day, yr.) September 10, 1878  
6.(c) If alive, give age — years

8. AGE: Years 69 Months 5 Days 9 If less than one day — hrs. — min.

9. Birthplace Burkettsville, Maryland  
(Town, county, and state)

10. Usual occupation Not available - Retired

11. Industry or business Same as above

12. Name Martin Hightman

13. Birthplace Maryland

14. Maiden name Heretta Arnold

15. Birthplace Virginia

18. Informant Charts & Records - Wash. San. & Hosp.

Address 700 Carroll Avenue, Takoma Park, Md.

17. Burial Date thereof Feb 21 - 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Prince Georges County

18. Funeral director S. H. Hines Co.

Address 2901 14th St Wash. D.C.

19. Feb 19 48 19 48 Registrar John D. Dobb  
(Date rec'd by registrar)

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 19 48 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 47 to Feb 19 19 48  
and that I last saw him alive on Feb 18 19 48

Immediate cause of death coronary occlusion DURATION 36 hrs

Due to coronary sclerosis 1 year

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Daniel B Washington MD M.D. or other —

Address 6234 7th Ave NW Wash DC Date signed 2/19/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

FEB 23 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 10 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3342 Baker St., N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

HOLMES, George Edward

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Harriet Holmes  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 14, 1888  
 8. AGE: Years 59 Months 7 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation Painter  
 11. Industry or business \_\_\_\_\_  
 12. Name HOLMES, Henry dec.  
 13. Birthplace Wash., D.C.  
 14. Maiden name ROBERTSON, Evelyn dec.  
 15. Birthplace Wash., D.C.

16. Informant wife: Mrs. Harriet Holmes  
 Address 3342 Baker St., N.E., Wash., D.C.  
 17. burial Date thereof 2-14-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Washington National  
 Location Suitland, Md. C.  
 18. Funeral director Lee Funeral Home  
 Address 4th & Mass., Avenue, N.W., Wash., D.C.  
 19. 2-12 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 February 19 48 at 9:45P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Dec. 19 47 to 12 Feb. 19 48  
 and that I last saw him alive on 12 February 19 48

Immediate cause of death

DURATION

Due to

Due to

Other condition

(Include pregnancy within 3 months of death)

Major findings of operation

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address USNH Bethesda, Md. Date signed 2-12-48

RECEIVED  
FEB 17 1948

RECEIVED  
FEB 17 1948  
RUSSELL S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01814

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1530 Red Oak Drive

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1530 Red Oak Drive  
(If rural, give LOCATION)2.(a) If veteran, name war ----

## 3. (a) FULL NAME

MARGARET L. HOLZ

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband Emil H. Holz6.(c) If alive, give age ---- years

7. Birth date of

deceased (mo., day, yr.) Nov. 6, 1896

8. AGE:

Years

Months

Days

If less than one day

5131

hrs.

min.

9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name William E. Dixon13. Birthplace Washington, D. C.14. Maiden name Margaret A. Garrison15. Birthplace Washington, D. C.16. Informant Mrs. Paul Berkeley, daughter D.C.Address 1238 Van Buren St., N. W., Washington,17. Burial Feb. 9, 1948  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Cedar Hill SanctuaryLocation Suitland, Md.18. Funeral director Warner E. HumphreyAddress Silver Spring, Md.19. Feb 8 19 48 Josephine Schaeffe  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

---

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med. exam 1948 to 1948  
and that I last saw h. alive on 1948

Immediate cause of death

DURATION

Coronary occlusionFound dead in bed

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ---- Date of ----Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Bruchart M.D. M. D. or otherAddress Yakobsoning mch Date signed 2-8-48

RECEIVED

FEB 12 1948

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01815 Y14

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

708 Sligo Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 708 Sligo Ave.  
(If rural, give LOCATION)2. (a) If veteran, name war no

## 3. (a) FULL NAME

Isaac Elsworth Keiser

## 3. (b) Social Security Number

none

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Alice R.

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.) Aug. 1st. 1862

## 8. AGE:

Years

85

Months

6

Days

4

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Ohio

(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

## FATHER

## 12. Name

Daniel Keiser

## MOTHER

## 13. Birthplace

Ohio

## 14. Maiden name

Unknown Overhaltz

## 15. Birthplace

Unknown

## 16. Informant

Rhettta Keiser Ammann

## Address

328 American Ave.Long Beach # 2, Cal.17. Cremation  
(Burial, cremation, or removal. Which?)Date thereof Feb. 13, 1948  
(month) (day) (year)

## 18. Cemetery or crematory

Cedar Hill Crematory

## Location

Exittland, Pr. Geo. Co., Md.

## 19. Funeral director

Warner E. Pumphrey

## Address

Silver Spring, Md. E.E.A.24-13  
(Date rec'd by registrar)

1948

Joseph H. Schaeffer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 17, 1940 to 2-5-48  
and that I last saw him alive on 2-4-48

Immediate cause of death

Lachrya and malnutrition

DURATION

2 months

Due to

Seizure & generalized asthenia10 years

Due to

Chronic nephritis5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

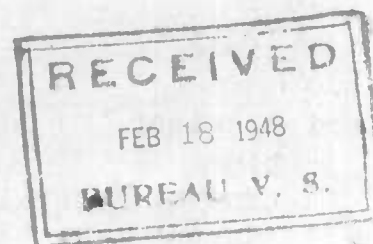
Injured at work?

23. SIGNATURE

W. E. Schaeffer

M. D. or other

Address 8005 Woodbury DriveDate signed 2/5/48Silver Spring, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01816 218

### 1. PLACE OF DEATH:

County Montgomery  
City or town Olney  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 weeks  
Hospital, institution, or street address where death occurred:  
Montgomery County General Hospital  
How long in hospital or institution? 6 wks

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town German Town  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

JAMES W. KESSELL

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Oliver Kessell  
7. Birth date of deceased (mo., day, yr.) April 4, 1879 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 68 Months 10 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hardy County West Virginia  
(Town, county, and state)  
10. Usual occupation Machine Tool Worker  
11. Industry or business None  
12. Name James Kessell  
13. Birthplace West Virginia  
14. Maiden name Elizabeth Thom  
15. Birthplace West Virginia  
16. Informant Hospital Records  
Address \_\_\_\_\_

17. Buried Date thereof 2/16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory David Memorial  
Location Cumberland Md.  
18. Funeral director Wm. Wright  
Address Cumberland Md.  
19. Feb 14 19 48 Charles S. Goode  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1948 at 5:55 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1948 to Feb 14, 1948  
and that I last saw him alive on Feb 14, 1948

Immediate cause of death Tuberculosis DURATION 6 months

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Syphilitic Aortitis 3 1/2 yrs  
Bleeding Internal Hemorrhoids 3 months  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
Address Sandy Spring, Md. Date signed 2/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

FEB 17 1943

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01817 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? one year  
 Hospital, institution, or street address where death occurred  
RFD 2 Briggs Cherry & Colonsville Rd  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD 2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Stephen Gerard King

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married  
 B. (b) Name of husband or wife Isabelle V King  
 7. Birth date of deceased (mo., day, yr.) Apr. 30, 1864  
 6. (c) If alive, give age 78 years

8. AGE: Years Months Days If less than one day  
83 10 18 .....hrs. ....min.

9. Birthplace Lemontown, St. Marys, Md  
(Town, county, and state)10. Usual occupation retired

11. Industry or business

FATHER 12. Name John F King  
 13. Birthplace Lemontown, St. Marys, Md

MOTHER 14. Maiden name H. Anderson  
 15. Birthplace Lemontown, St. Marys, Md

16. Informant John F KingAddress RFD 2 - Briggs Cherry & Colonsville Rd

17. (Burial, cremation, or removal, Which?) Burial Date thereof Feb. 19, 1948  
 (month) (day) (year)

Cemetery or crematory St. AloysiusLocation Lemontown, Md18. Funeral director Joseph L. SmattinglyAddress Lemontown, Md

19. Feb 19 19 48 Joseph W. Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 19 48, at 4 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
Feb 19 19 48 to Feb 19 19 48  
 and that I last saw him alive on 2 a.m. Feb 19 19 48

Immediate cause of death Coronary occlusion  
 DURATION 24 hrs.

Due to

Due to

Other conditions no history of other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John N. Andrews M. D. or other  
9601 Colonsville Rd  
 Address Silver Spring, Md Date signed Feb 19, 48

CERTIFICATE OF DEATH

RECEIVED  
FEB 2 1948  
BUREAU V. S.

*Handwritten notes and signatures:*  
14710-19-102  
J. H. [illegible]  
[illegible]  
[illegible]  
[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01818

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Patoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11 Columbia Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Patoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Columbia Ave - Branch  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edward Quintus Knight

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Edith B. Knight

7. Birth date of

deceased (mo., day, yr.)

Sept. 16 - 1871

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76422

hrs.

min.

9. Birthplace

Washington - DC  
(Town, county, and state)

10. Usual occupation

Retired Government

11. Industry or business

FATHER

12. Name

Charles Knight

13. Birthplace

England

MOTHER

14. Maiden name

May Simpson

15. Birthplace

Black - Rock - New York

16. Informant

Address

11 Columbia Ave - Branch

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 1948  
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Prince Georges County

18. Funeral director

Address

254 Canal St - Baltimore

19.

(Date rec'd by registrar)

19

Feb 18 48  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med Exam case 1948 to 1948  
and that I last saw him alive on 1948

Immediate cause of death

Coronary occlusion

DURATION

 died suddenly

Due to

Cerebral accident12-1-47

Other conditions

Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschart M.D.  
Def med Exam

M. D. or other

Address

Yarthingburg rd Date signed 2-9-48







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01819

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? two months  
 Hospital, institution, or street address where death occurred:  
9714 Colesville Road.  
 Now long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Virginia County Fairfax  
 City or town Clifton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Richard Montimore La Roche

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.  
 6. (b) Name of husband or wife Pauline  
 7. Birth date of deceased (mo., day, yr.) November 20, 1906  
 6. (c) If alive, give age 39+ years  
 8. AGE: Years 41 Months 2 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation Librarian  
 11. Industry or business Library of Congress  
 12. Name William Montimore La Roche  
 13. Birthplace Charleston, S. C.  
 14. Maiden name Carrie Parker  
 15. Birthplace Culpepper Virginia -  
wife

16. Informant Burial Address Clifton, RFD, Fairfax Co. Virginia  
 17. (Burial, cremation, or removal, Which?) Burial Date thereof Feb 11, 1948  
 (month) (day) (year)  
 Cemetery or crematory National Memorial Park  
 Location Falls Church, Va.  
 18. Funeral director Warner E. Rumphrey  
 Address Silver Spring, Md.  
 19. Feb 10 19 48 Josephine Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-48 at 4:40 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 47 to 2-8-48  
 and that I last saw him alive on 2-8-48

Immediate cause of death Hypernephroma Right Kidney  
 DURATION one Year-

Due to Generalized Carcinomatosis 5 weeks  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

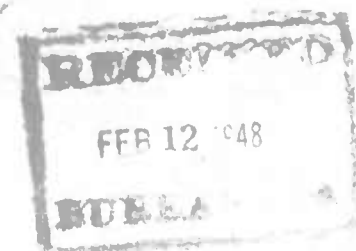
Major findings of operations Carcinoma Rt. Kidney with Metastases Date of op. 12-4-47  
 Autopsy results not done  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. Shewskur  
8005 Woodbury Drive; Silver Spring, Md.  
 Address \_\_\_\_\_ Date signed 2-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01820

2/16

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.Hospital, institution, or street address where death occurred:  
620 Pickwick LaneHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 620 Pickwick Lane(If rural, give LOCATION)  
None

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Ida Carter Leonard

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Jesse Leonard7. Birth date of deceased (mo., day, yr.) September 1st, 1867 6. (c) If alive, give age dec. years8. AGE: Years 80 Months 5 Days 8 It less than one day  
..... hrs. .... min.9. Birthplace Alexandria, Ohio  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Rufus R. Carter  
13. Birthplace Ohio14. Maiden name Martha Ann Wickiser  
15. Birthplace Ohio16. Informant Mrs. Ray T. Watkins  
Address Chevy Chase, Maryland17. Shipment Date thereof Feb. 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Basil, OhioLocation Basil, Ohio18. Funeral director Wm E JonesAddress Bethesda, Maryland19. 2/10 19 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 February 1948 at 10:45 pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 19 47, to 9 Feb 19 48and that I last saw her alive on 9 February 19 48Immediate cause of death Diabetes Mellitus  
with Diabetic coma & Acidosis. 5 yrs  
48 hrsDue to Cause unknown.

Due to

Due to

Other conditions Gangrene, diabetic, left foot. 1 month  
Quadruplegia, Arteriosclerosis, general. 5 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart Bluff, M.D.Address 321 Ingomar St. N.W. Wash. D.C. Date signed 9 Feb '48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

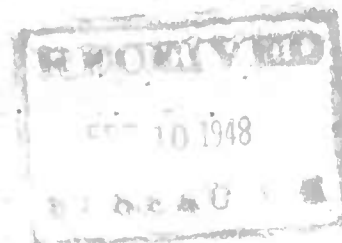
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01822

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 25 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 915 Crawford Drive  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

MAJOR, Willard Alexander

### 3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Briarly H. Major  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) September 6, 1892  
8. AGE: Years 55 Months 5 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mass.  
(Town, county, and state)  
10. Usual occupation unknown  
11. Industry or business  
12. Name MAJOR, Wilfred dec.  
13. Birthplace Mass.  
14. Maiden name LaBLAC, Julia A. dec.  
15. Birthplace Canada

16. Informant Wife: Mrs. Briarly H. Major  
Address 915 Crawford Drive, Rockville, Md.  
17. burial Date thereof 1-17-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Arlington, Va.  
Location  
18. Funeral director W. W. CHAMBERS  
Address 1400 Chapin St., N.W., Wash., D.C.  
Mary C. Patterson  
Mary C. Patterson

19. 2-16 19 48  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 15 February 19 48 at 11:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Feb. 19 48 to 15 Feb. 19 48  
and that I last saw him alive on 15 February 19 48

Immediate cause of death Coronary Thrombosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ injured at work?

23. SIGNATURE H. R. Cooper H. R. COOPER, Lt. MC USN  
M. D. or other  
Address USNH Bethesda, Md. Date signed 2-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01823-4

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma PARK  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town SILVER SPRING  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9000 Flower Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

MRS. Ruth Dorothy MARKS

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White American 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mr. William OSCAR MARKS6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) MARCH 3, 19028. AGE: Years 45 Months 11 Days 21 If less than one day  
..... hrs. .... min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name HENRY CORRELL13. Birthplace Massachusetts14. Maiden name Ida Haislip15. Birthplace Washington DC.16. Informant Hospital records

Address

17. Burial Date thereof Mar. 3 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln Cem.Location Prince Georges Co. Md.18. Funeral director S. A. Hines Co.Address 2901-14th N.W. Wash. D.C.19. March 1, 48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 29 19 48 at 12<sup>10</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-1-48 to 2-29-48and that I last saw him alive on 2-29-48Immediate cause of death uremia DURATION 10 daysDue to chronic nephritis 2 yearsDue to the generalized arteriosclerosis 1 yearOther conditions pneumonia, lobes 1 week  
(47-48)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Shumaker M. D. or otherAddress 8005 Woodbury Dr - Silver Spring, Md Date signed 2/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01824

Reg. Dist. No. 253

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 days 2 hrs  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital.  
 How long in hospital or institution? 4 days 2 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7434 Wisconsin Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas Mathieson, Sr.

## 3. (b) Social Security Number

579-03-3882

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Martha Mathieson  
 7. Birth date of deceased (mo., day, yr.) March 7, 1884 6.(c) If alive, give age 63 years  
 8. AGE: Years 63 Months 11 Days 25 It less than one day 2 hrs. \_\_\_\_\_ min.

9. Birthplace Scotland  
 (Town, county, and state)  
 10. Usual occupation Builder  
 11. Industry or business Cladney Const. Co.  
 12. Name Robertson B. Mathieson  
 13. Birthplace Scotland  
 14. Maiden name Jean Hannah  
 15. Birthplace Scotland

16. Informant Sanitarium Records  
 Address Takoma Park, Maryland  
 17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb. 14, 1948  
 (month) (day) (year)  
 Cemetery or crematory Rock Creek Cemetery  
 Location Washington, D.C.  
 18. Funeral director Wm. Randolph Humphrey  
 Address Bethesda, Maryland  
 19. Feb. 13, 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1948 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to Feb. 11 1948  
 and that I last saw him alive on Feb. 10 1948

Immediate cause of death BRONCHIAL PNEUMONIA DURATION 3 days

Due to CORONARY THROMBOSIS 41 days

Due to GENERALIZED ARTERIOSCLEROSIS 5 years

Other conditions \_\_\_\_\_

(Include pregnancy within 5 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results As stated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Bruce F. Benjamin, M.D. M. D. or otherAddress Bethesda, Md. Date signed 2/16/48

**RECEIVED**

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01825

214

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 yrs -  
 Hospital, institution, or street address where death occurred:  
751 Sligo Dr.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Montgomery  
 City or town... Silver Spring Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 751 Sligo Dr.  
 (If rural, give LOCATION)  
 2(a) If veteran, memo war

## 3. (a) FULL NAME

MCCAULEY, Miss ENNA DELIA

## 3. (b) Social Security Number

-

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife -8. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) SEPT 9, 1873

8. AGE: Years 74 Months 4 Days 27 If less than one day  
 hrs. min.

9. Birthplace Frankfort, Kentucky  
(town, county, and state)10. Usual occupation clerk - retired11. Industry or business U. S. Gov. Printing office12. Name John Robert McCauley13. Birthplace Madison, Ind.14. Maiden name Bessie Ann Ellis15. Birthplace Frankfort, Kentucky16. Informant Mr Daniel CarrAddress 751 Sligo Dr. S.S. Md.17. BURIAL Date thereof FEB - 9<sup>TH</sup> 1948  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or cremators CEDAR HILLLocation PRINCE GEORGES CO - MD18. Funeral director Warner E. HumphreyAddress SILVER SPRING - MD19. 24 - 8 19 48 Joseph W. Schaeffle  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 48 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-19 19 45, to 2-5 19 48and that I last saw him alive on 2-4 19 48Immediate cause of death PneumoniaHypostaticDURATION 2 daysDue to Cancer of liver (Carcinoma) 1 1/2 yrs.secondaryDue to Cancer of transverse 2 yrs.colon - (Carcinoma) 4 yrs.Other conditions Anemia

(Include pregnancy within 3 months of death)

Major findings of operations Adenocarcinoma of colonwith nearly complete obstruction Date of op. 2-13-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Mitchell, M.D. M. D. or otherAddress Silver Spring, Md Date signed 2-6-48

CIVIL CASE OF DEATH

STATE DEPARTMENT OF HEALTH

CASE OF DEATH

NOTIFICATION

**RECEIVED**  
FEB 12 1948  
FEB 12 1948

RECEIVED STATE DEPARTMENT OF HEALTH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Takoma Park, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 hr.  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Montgomery  
 City or town... Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1902 Lansdowne Way  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Douglas Stephen McKinney

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife -----  
 6.(c) If alive, give age ----- years  
 7. Birth date of deceased (mo., day, yr.) November 4, 1945  
 8. AGE: Years 2 Months 3 Days 9 If less than one day ----- hrs. ----- min.

9. Birthplace... Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business -----  
 12. Name John D. McKinney  
 13. Birthplace Washington, D.C.  
 14. Maiden name Druscilla Hartley  
 15. Birthplace Rhode Island

16. Informant Neal B. McKinney  
 Address 7203 Cobalt Rd., Wood Acres, Md.  
 17. Burial Date thereof 2/17/48  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln  
 Location Harmon & Humphrey  
 18. Funeral director Silver Spring  
 Address Feb 15 1948  
 19. Feb 15 1948 (Date rec'd by registrar) William Dodd Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948 at 12:09 M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11 1948 to Feb 13 1948  
 and that I last saw him alive on Feb 13 1948  
 Immediate cause of death Ac. Respiratory Infection  
 Due to Probably Virus  
 Due to Fall  
 Other conditions Fully infected from Listeria  
Pastoral & telephonic  
Compromised kidneys  
 Major findings of operations ----- Date of op. -----  
 Autopsy results None as a basis  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ----- Date of -----  
 Where did injury occur? ----- (City or town) ----- (County) ----- (State)  
 Injured at home, farm, industry, public place (where?) -----  
 Means of injury ----- Injured at work? -----  
 23. SIGNATURE W. H. Wood. M.D.  
 Address 2310 Lane Ave. Date signed 2/15/48  
 M. D. or other -----

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FEB 18 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01827

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 13 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ADELINE MEADS

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Negro Married6. (b) Name of husband ~~XXXX~~ Jessie Meads7. Birth date of deceased (mo., day, yr.) Sept. 21, 1901  
6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years Months Days If less than one day  
46 3 5 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Boysd, Mont. Co., Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Edward Campbell13. Birthplace Boysd, Mont. Co., Maryland14. Maiden name Sarah Boynes15. Birthplace Boysd, Mont. Co., Maryland16. Informant Sarah Meads (daughter)Address Rockville, Md17. Burial Date thereof Feb 29, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St MarksLocation Boysd, Maryland18. Funeral director B. L. SwansonAddress Rockville, Maryland19. 2/27 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 19 48, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Stein case 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

acute yellow atrophy of  
the liver

DURATION

2x hrsCause Extensive fresh hemorrhage  
of the lungs (not due to tuberculosis)  
(4648. as)Other conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Frank J. Broschart M.D.  
Dep med Stein M. D. or otherAddress Gaithersburg Md Date signed 2-28-48

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MAR 3 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

01828

## 1. PLACE OF DEATH

County Montgomery Registration Dist. No. 216  
 Village or City Bethesda Suburban No. hosp St.  Ward   
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred  yrs.  mos.  ds. How long in U.S. if of foreign birth?  yrs.  mos.  ds.

## 2. FULL NAME

Joseph D Mitchell If U. S. Veteran, specify WAR   
 (a) Residence: No. 3908 Oliver St Chevys Chase Maryland  
 (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

|  |                                  |   |                   |
|--|----------------------------------|---|-------------------|
| 3. SEX<br><u>Male</u>  | 4. COLOR OR RACE<br><u>White</u> | 5. SINGLE, MARRIED, WIDOWED,<br>OR DIVORCED ( <u>write the word</u> ) |                   |
| 5a. If married, widowed, or divorced<br>HUSBAND of<br>(or) WIFE of |                                  |   |                   |
| 6. DATE OF BIRTH (month, day, and year) <u>December 20, 1865</u>   |                                  |   |                   |
| 7. AGE<br><u>82</u>  | Years<br><u>82</u>               | Months<br><u>1</u>  | Days<br><u>18</u> |
|  |                                  | If LESS than<br>1 day, <u></u> hrs.<br>or <u></u> min.                |                   |

|            |   |
|------------|---|
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Bookbinder</u> |
|            | 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u></u>                    |
|            | 10. Data deceased last worked at this occupation (month and year) <u></u>                                     |
|            | 11. Total time (years) spent in this occupation <u></u>   |

12. BIRTHPLACE (city or town) Cincinnati, Ohio  
 (State or country)

FATHER  
 13. NAME John Mitchell  
 14. BIRTHPLACE (city or town) Ireland  
 (State or country)

MOTHER  
 15. MAIDEN NAME Ellen Heard  
 16. BIRTHPLACE (city or town) Ireland  
 (State or country)

17. INFORMANT J. H. R. Records  
 (Address)

18. BURIAL, CREMATION, OR REMOVAL  
 Place mt oliver ben Nash, DC  
 Date , 19

19. UNOERTAKER Frederick Haulow  
 (Address) 641 - H St NE

20. FILED 2/8, 19 Wm E. Jones  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

February 8, 1948  
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 7, 1946, to Feb. 8, 1948

I last saw him alive on 7 Feb., 1948; death is said to have occurred on the date stated above, at 6:30 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 5/26/48

Other Contributory Causes of Importance:

Severe Arteriosclerosis

Name of operation none Date of   
 What test confirmed diagnosis?  Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?  Date of Injury , 19

Where did Injury occur?

(Specify city or town, county and State)  
 Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or Injury in any way related to occupation of deceased? no

If so, specify

(Signed) J. H. R. Records M. D.  
 (Address) Takoma Park, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

|  | Date of onset       |
|--|---------------------|
| <i>Arteriosclerosis</i>                  | <i>1915</i>         |
| <i>Chronic interstitial nephritis</i>    | <i>1921</i>         |
| <i>Cerebral hemorrhage</i>               | <i>July 5, 1927</i> |
|  |                     |
| Other contributory causes of importance: |                     |
| <i>Gallstones</i>                        | <i>May 1, 1923</i>  |
|  |                     |
|  |                     |

## Example II

The principal cause of death and related causes of importance were as follows:

|  | Date of onset     |
|--|-------------------|
| <i>Attack of epilepsy</i>                | <i>1 week ago</i> |
| <i>Run over by street car</i>            | <i>1 week ago</i> |
| <i>Peritonitis</i>                       | <i>3 days ago</i> |
|  |                   |
| Other contributory causes of importance: |                   |
| <i>Gastroenteritis</i>                   | <i>1 year</i>     |
|  |                   |
|  |                   |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 Hours  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium and Hospital  
 How long in hospital or institution? 24 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MONTGOMERY  
 City or town Silver Springs  
 (If outside city or town limits write RURAL and give nearest town)  
 Street No. Route #2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. Ralph Donald Monard

## 3. (b) Social Security Number

217-16-2870

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mrs. Elsie Jane Monard  
 7. Birth date of deceased (mo., day, yr.) August 7, 1922 6.(c) If alive, give age 19 years  
 8. AGE: Years 25 Months 6 Days 15 If less than one day  
hrs. min.

9. Birthplace Dickerson, Maryland  
 (Town, county and state)  
 10. Usual occupation (not employed)  
 11. Industry or business

FATHER 12. Name LEWIS MONARD  
 13. Birthplace MO  
 MOTHER 14. Maiden name NETTIE  
 15. Birthplace MO

16. Informant MRS. ELSIE JANE MONARD  
 Address BRIGGS CHANEY RD. SILVER SPRING MD  
 17. BURIAL Date thereof FEB. 25 - 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory COLESVILLE CHURCH  
 Location COLESVILLE, MONTG. CO. MD

18. Funeral director W. J. E. Humphrey, Jr.  
 Address SILVER SPRING, MD  
 19. Feb. 24 19 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-48 19 at 11:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 19 to 2/22/48 19

and that I last saw him alive on 2/22/48 19

Immediate cause of death Thyroid carcinoma of brain  
metastatic postoperative

Due to  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)  
 Major findings of operations Spinal Phis. Spinal Dis.  
Sept 4 - 1946 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Car Injured at work?  
 23. SIGNATURE W. J. E. Humphrey, Jr. M. D. or other  
 Address 8252 Silver Spring Rd Date signed 2/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01830

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town R.F.D. - Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 Years  
 Hospital, institution, or street address where death occurred:  
6104 MacArthur Blvd.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town R.F.D. - Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6104 MacArthur Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

LUCY HOLBROOK MOORE

## 3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Henry Frank Moore  
 6.(c) If alive, give age 80 years  
 7. Birth date of deceased (mo., day, yr.) May 11, 1871  
 8. AGE: Years 76 Months 76 Days 9 It less than one day 13 hrs. min.

9. Birthplace Providence, Rhode Island  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business None

FATHER 12. Name Unknown Baxter  
 13. Birthplace Unknown  
 MOTHER 14. Maiden name Unknown Snow  
 15. Birthplace Unknown

16. Informant Henry Frank Moore  
 Address R.F.D., Bethesda, Maryland  
 17. Burial Date thereof Feb. 27, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Nat'l Memorial Park  
 Location Fairfax, Virginia  
 18. Funeral director Wm. Landon Humphrey  
 Address Bethesda, Maryland

19. Feb 26 19 48  
 (Date rec'd by registrar) Registrar H. M. E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948 at 11 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examination Case 19 48  
 and that I last saw him alive on 19

Immediate cause of death Coronary occlusion DURATION 1 1/2 hours

Due to Chronic arteriosclerosis  
 Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

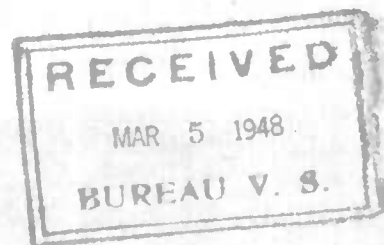
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Bauerfeldt M.D. M. D. of otherAddress Bethesda, Md. Date signed 2-24-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01831 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
11 Philadelphia Avenue  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 11 Philadelphia Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

### 3. (a) FULL NAME

ELISE NEUMANN

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Felix Neumann  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) August 1860  
8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Breslew, Germany  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Breslew, Germany  
14. Maiden name Unknown  
15. Birthplace Breslew, Germany

16. Informant Robert Cohn, M.D.  
Address Pyle Road, Bethesda, Maryland

17. Burial Cremation Date thereof Feb. 12/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cem.

Location Prince Georges County

18. Funeral director S. A. Vines Co.

Address 2901-14th St. N.W. Washington, D.C.

19. Feb 10 19 48  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 48 at 11:50 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 47 to 9 Feb 48 and that I last saw her alive on 2/2/48

Immediate cause of death Acute Heart Failure DURATION 10 min

Due to Chronic Atherosclerosis  
Heart disease 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George H. Lustig M. D. or other

Address 1852 Columbia Rd. NW Date signed 2/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

01832

### 1. PLACE OF DEATH:

County Montgomery  
City or town Chevy Chase, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? LIFE  
Hospital, institution, or street address where death occurred:  
#1 Kenilworth Drive Chevy Chase, Md.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 41 Kenilworth Dr  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

### 3. (a) FULL NAME

CHARLES EIRICH NORRIS

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife Mary A.

7. Birth date of deceased (mo., day, yr.) Jan 20, 1869 6.(c) If alive, give age 18 70 years

8. AGE: 78 Years Months Days If less than one day  
.....hrs. ....min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Landscape Gardener

11. Industry or business

12. Name John W. Norris

13. Birthplace Maryland

14. Maiden name Charlotte Kingston

15. Birthplace Maryland

16. Informant Allen M. Norris

Address #1 Kenilworth Dr. Chevy Chase, Md.

17. Burial Date thereof Feb 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Wash. Nat'l Cem. Md.

Location Suitland, Md.

18. Funeral director W.W. Chambers Co.

Address 3072 Mt. Mt. Wash. D.C.

19. 21 11 19 48 Wm E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 10 19 48 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 19 45, to FEB 10 19 48

and that I last saw him alive on FEB 10 19 48

Immediate cause of death PULMONARY EDEMA DURATION 12 hours

Due to HYPERTENSION

Due to CEREBRAL VASCULAR HEMORRHAGE 4 MONTHS

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.P. Andrews M.D. M. D. or other D.C.  
Address 4201 Euclid St NW Wash. D.C. Date signed 2-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

Evidence for change of  
birth date and age shown

MARYLAND STATE DEPARTMENT OF HEALTH

on:

2411 N. Charles St., Baltimore

100 L

9

01833

216

CERTIFICATE OF DEATH

Reg. Dist. No. ....

FILM No. G 111 MAR 17 1948

1. PLACE OF DEATH:

County..... Montgomery  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 3 months, 6 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution?..... 3 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va. County.....  
City or town..... Vienna  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. .... Route #1  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... WWII

3. (a) FULL NAME

OLIVER, George Alfred

3. (b) Social Security Number

4. Sex..... male  
5. Color or race..... W-US  
6. (a) Single, married, widowed, or divorced..... married  
6. (b) Name of husband or wife..... Gertrude C. Oliver  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... November 6, 1915 1914  
8. AGE: Years..... 33 33 Months..... 3 Days..... 18  
If less than one day..... hrs. .... min.

9. Birthplace..... Va.  
(Town, county, and state)  
10. Usual occupation..... Supt. of school grounds  
11. Industry or business..... Frederic School, Fairfax Co Va  
FATHER  
12. Name..... OLIVER, Harry L.  
13. Birthplace..... Va.  
MOTHER  
14. Maiden name..... DOWNNEY, Annie  
15. Birthplace..... D.C.

16. Informant..... wife: Mrs. Gertrude C. Oliver  
Address..... Vienna, Va., Rt. #1  
burial  
17. (Burial, cremation, or removal, Which?) Date thereof..... Feb 27, 1948  
(month) (day) (year)  
Cemetery or crematory..... Salem Cemetery  
Forestville, Va.  
Location.....  
18. Funeral director..... O. C. Pearson  
Address..... Falls Church, Va.  
2-25 48 Mary C. Patterson  
19. (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 24 February 19 48 at 7:30 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 18 19 47 to 24 Feb. 19 48  
and that I last saw h in alive on 24 Feb. 19 48

Immediate cause of death.....  
Embolism (Pulmonary)  
DURATION  
2 hrs.  
Due to..... Thrombosis, Pelvic Veins 2 mons.  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?.....  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Mens of injury..... Injured at work?

23. SIGNATURE..... H.R. Cooper  
H.R. COOPER, Lt. MC USN or other  
Address..... USNH Bethesda, Md. Date signed..... 2-25-48

MARGIN RESERVED FOR BINDING

VS A45 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01834 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town (Rural) Bethesda, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
National Naval Medical Center, Bethesda, Md.  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash., D.C. County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2415 E. St. NW  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Paiste, Felix Andrew

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced S  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 2-20-48  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 22 hrs. \_\_\_\_\_ min.

9. Birthplace Bethesda, Montgomery, Maryland  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Felix A. Paiste  
 13. Birthplace Ohio  
 14. Maiden name Elizabeth Exline  
 15. Birthplace Kansas

16. Informant father: Mr. Felix A. PaisteAddress 2415 E. St., N.W., Wash., D.C.

17. Burial Date thereof Feb 23, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
Arlington, Va.  
 Location \_\_\_\_\_

18. Funeral director P. J. SAFFELLAddress 475 H St. NW Washington, D.C.

19. 2-21 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 48 at 7:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Feb. 48 to 21 Feb. 48  
 and that I last saw him in the on 21 February 48

Immediate cause of death Intracranial hemorrhage DURATION \_\_\_\_\_  
# 2133

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. T. FOWLER, Jr. Cdr. MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 2-21-48

RECEIVED

FEB 27 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

01835

93d

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 days  
 Hospital, institution, or street address where death occurred:  
Washington San. Hosp.  
 How long in hospital or institution? 20 days, 6 hrs. 35 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... DC County...  
 City or town... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 128 Carroll St. SE.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Mrs. Nellie Parater

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow  
 8. AGE: Years 70 Months H Days 14 If less than one day  
 10. Usual occupation House wife  
 11. Industry or business

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1877  
 9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 12. Name ?  
 13. Birthplace Washington, DC.  
 14. Maiden name Nellie Lock  
 15. Birthplace Washington, DC.

16. Informant SON - Wm. L. Staffel  
 Address 128 Carroll St. SE, DC.  
 17. Burial Date thereof ✓ (month) (day) (year)  
 Cemetery or crematory ✓  
 Location W. W. Chambers Co  
 18. Funeral director W. W. Chambers Co  
 Address 517-11th St, S.E.  
 19. 2-28- 19 48  
 (Date rec'd by registrar) Registrar John H. [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 19 48 at 11:20 a M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 19 47 to 2-28 19 48  
 and that I last saw her alive on 2-28 19 48

Immediate cause of death Acute Cardiac Failure  
 DUE TO Hypertension Cardiovascular  
 Due to same  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Manner of injury Injured at work?

23. SIGNATURE John H. [Signature] M.D.  
 Address 113 Carroll St NW Wash DC. Date signed 2-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR. 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 daysHospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.How long in hospital or institution? 26 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County .....City or town Alexandria  
(If outside city or town limits, write RURAL and give nearest town)Street No. 810 N. Columbiastreet  
(If rural, give LOCATION)2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

PARKER, Eugene (n)

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Negro separated6. (b) Name of husband or wife Pauline Parker7. Birth date of deceased (mo., day, yr.) December 22, 1884  
6. (c) If alive, give age ..... years8. AGE: Years Months Days If less than one day  
63 2 6 ..... hrs. .... min.9. Birthplace Va.  
(Town, county, and state)10. Usual occupation unknown

11. Industry or business

12. Name PARKER, Martin ded.13. Birthplace Va.14. Maiden name Sarah Hooe dec.15. Birthplace Va.16. Informant sister: Mrs. Blanch TaylorAddress 214 N. Payne St., Alexandria, Va.17. burial Date thereof 3-4-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Lloyd A. Lewis JCLAddress 800 Wolfe St., Alexandria, Virginia19. 2-28 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 February 19 48 at 0530 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2 Feb. 19 48 to 28 Feb. 19 48  
and that I last saw h. im alive on 28 Feb. 19 48Immediate cause of death Bronchopneumonia DURATION 48 hrs.Due to Adenocarcinoma of stomach 2 yrs.  
with metastases

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

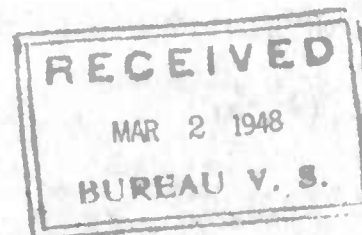
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury W. F. Harrison, Jr. injured at work?23. SIGNATURE W. F. HARRISON, Lt. MC USN  
M. D. or otherUSNH Bethesda, Md. 2-28-48  
Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01837

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County Montg.  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo  
 Hospital, institution, or street address where death occurred:

Anderson Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montg. County Montg.  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Anderson Ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Helene C. Pearson

## 3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.) Apr 2 1944

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

31011

hrs.

min.

9. Birthplace Almy Md  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Clifford Pearson13. Birthplace Ida14. Maiden name Lena Posey15. Birthplace Ida16. Informant Mrs Clifford PearsonAddress Rockville Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 15, 1948  
 (month) (day) (year)

Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director W. Kenner ClineberryAddress Bethesda, Maryland19. 214

(Date rec'd by registrar)

19 48

EP Shoupson  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19 to Jan. 19  
 and that I last saw him Sept. 19 alive on Sept. 19

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

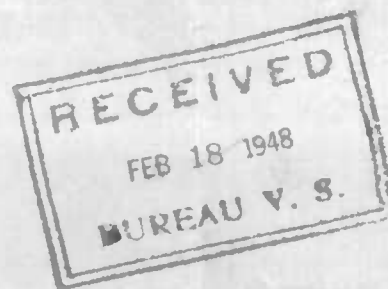
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 2-13-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

4211 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01838

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MONTGOMERY  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? SINCE 2-2-48  
 Hospital, institution, or street address where death occurred:  
SUBURBAN HOSP  
 How long in hospital or institution? SINCE 2-2-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MONTGOMERY  
 City or town BETHESDA  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9100 - OLD GEORGETOWN, Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

SARAH GILLETTE WARD PHELPS

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

W<sup>M</sup> J. PHELPS

## 6.(b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

JUNE 24, 1870

## 6.(c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

77

hrs.

min.

## 9. Birthplace

CHICAGO, ILL.

(Town, county, and state)

## 10. Usual occupation

HOUSE WIFE

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

LORENZO WARD

## 13. Birthplace

PALMER, MASS

## 14. Maiden name

ELLEN GILLETTE

## 15. Birthplace

E WINDSOR, CONN

## 18. Informant

CAPT. CASEY

## Address

## 17.

CREMATION  
(Burial, cremation, or removal, Which?)

## Date thereof

2-9-48  
(month) (day) (year)

## Cemetery or crematory

CEDAR, HILL

## Location

SUITLAND, MD

## 18. Funeral director

JOE GAWLERS SONS INC

## Address

1756 PENN. AVE, N.W

## 19.

218  
(Date rec'd by registrar)19. 48Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 19 48 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1219. 47to FEB 719. 48and that I last saw him alive on FEB 7 19. 48Immediate cause of death Hypertensive heart disease DURATIONDue to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

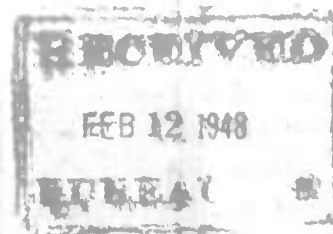
Injured at work?

23. SIGNATURE

Dr. Joseph P. Kucich

Address

7742 Wisconsin Ave, Bethesda, Md Date signed 2/7/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01839

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5603-Park St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Roy Pipes

## 3. (b) Social Security Number

--

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Edith Pipes  
 6.(c) If alive, give age 67 years  
 7. Birth date of deceased (mo., day, yr.) June 4, 1874  
 8. AGE: Years 73 Months 7 Days 27 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cameron, W. Va.  
 (Town, county, and state)  
 10. Usual occupation Interstate Commerce Commission  
 11. Industry or business U.S. Government

12. Name James M. Pipes  
 13. Birthplace Penna.  
 14. Maiden name Martha Purdy  
 15. Birthplace W. Va.

16. Informant Edith Pipes  
 Address 5603-Park St. Ch. Ch. Md.  
 17. Burial Date thereof 2/5/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Adams Hill  
Md.  
 Location \_\_\_\_\_

18. Funeral director S. H. Hines Co.  
 Address 2901-14th St. N.W.

19. 2/2 19 48 Mr E. John  
 (Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/48 at 9:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23/1906 to 1/23/48  
 and that I last saw him alive on 1/23/48

Immediate cause of death Coronary Thrombosis  
 Due to Coronary Artery  
disease  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

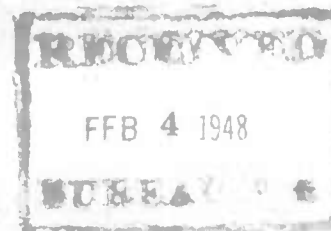
23. SIGNATURE S. R. Karpel M. D. or other \_\_\_\_\_  
 Address 3549-16th W.W. Date signed 2/2/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01840 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital 2nd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Monrovia  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #1 Near Damascus  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARY FRANCESPrather

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FemaleCol.—

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 28, 1948

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1 hrs.20 min.9. Birthplace Olney, Montgomery County, Maryland  
(Town, county, and state)

10. Usual occupation

Luxant

11. Industry or business

MOTHER FATHER

12. Name

Calvin Roosevelt Prather

13. Birthplace

Laytonville, Maryland

14. Maiden name

Mavis Bernice Zeitler

15. Birthplace

Damascus, Maryland

16. Informant

Hospital records

Address

17. Burial, cremation, or removal. Which?

Date thereof

March 2, 1948  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 2-28 1948  
(Date rec'd by registrar)Gertrude B. Lavelle  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1948 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 28, 1948 to February 27, 1948and that I last saw him/her alive on February 28, 1948Immediate cause of death Spiral Bilateral Infarctof Spine DURATION 1 hr. 30 min.Due to Bilateral club foot 1 hr. 30 min.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kern M.D. M. D. or otherDamascus, Md. Date signed 3/28/48

MARGIN RESERVED FOR BINDING

VS A15 9445-15M T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 12 1948

**BUREAU V. 8.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01841  
216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months, 24 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 3 months, 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Peru County \_\_\_\_\_  
 City or town Callao  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

RAYGADA, Jullio, Cdr. Peruvian Navy

## 3.(b) Social Security Number

4. Sex male 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Isabel de Raygada  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 4, 1904  
 8. AGE: Years 43 Months 3 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Callao, Peru  
 (Town, county, and state)  
 10. Usual occupation Peruvian Navy  
 11. Industry or business \_\_\_\_\_  
 12. Name RAYGADA, Jullio  
 13. Birthplace Peru  
 14. Maiden name CARRERA, Genoveva  
 15. Birthplace Peru

16. Informant wife: Mrs. Isabel de Raygada  
 Address Peruvian Embassy, Wash., D.C.  
 17. transportation Date thereof 2-11-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Baguijano Cemetery  
 Location Callao, Peru

18. Funeral director W. W. CHAMBERS  
 Address 1400 Chapin St., N.W., Wash., D.C.  
 19. 2-10 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 February 19 48 at 4:10 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Oct. 19 47 to 9 Feb. 19 48  
 and that I last saw him alive on 9 February 19 48

Immediate cause of death Cholemic nephrosis DURATION 2 wks  
 Due to Hodgkins lymphoma 2 1/2 yrs.  
generalized  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

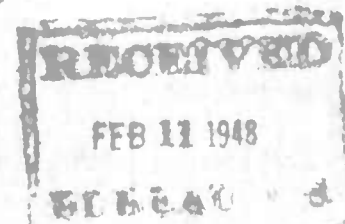
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury P. E. Williams Injured at work to (H)  
 23. SIGNATURE D. E. BILLMAN, Lt. (ig.) MC USN M. D. or other \_\_\_\_\_  
USNH Bethesda, Md. Date signed 2-10-48  
 Address \_\_\_\_\_

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **92d** **01842** **"L 216"**

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3325 N St., N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWI ✓

### 3. (a) FULL NAME

READY, Francis Joseph

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 7, 1884

8. AGE: Years 63 Months 6 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation Physician

11. Industry or business Retired Navy

FATHER 12. Name READY, Morris J.  
13. Birthplace Wash., D.C.

MOTHER 14. Maiden name HEAD, Bertha dec.  
15. Birthplace Wash., D.C.

16. Informant daughter: Mrs. J. W. McGovern, Jr.  
Address 3325 N St., N.W., Wash., D.C.

17. burial Date thereof 2-23-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Mt. Olivet  
Location Washington, D.C.

18. Funeral director P. J. SAFFELL By H. M. Day  
Address 475 H St., N.W., Wash., D.C.

19. 2-19 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 19 48 at 2:22 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Feb. 19 48 to 19 Feb. 19 48 and that I last saw him alive on 19 February 19 48

Immediate cause of death Hypertensive Heart Disease DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results confirmed above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. R. COOPER, Lt. Lt MC USN

Address USNH Bethesda, Md. Date signed 2-19-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.





*Handwritten:*  
D. P. Thompson  
v. 3

**RECEIVED**  
FEB 20 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 23 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1821 Corcoran St., N.W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... Sp. Am. War ✓

## 3. (a) FULL NAME

RICHARDS ON, George

## 3. (b) Social Security Number

4. Sex..... male  
 5. Color or race..... Col-US  
 6. (a) Single, married, widowed, or divorced..... single  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... March 4, 1877  
 8. AGE: Years..... 70 Months..... 11 Days..... 2 If less than one day..... hrs. .... min.

9. Birthplace..... Va.  
 (Town, county, and state)  
 10. Usual occupation..... Retired Service Personnel  
 11. Industry or business.....  
 12. Name..... Richardson, Peter dec.  
 13. Birthplace..... Ca.  
 14. Maiden name..... BOXLEY, Nancy dec.  
 15. Birthplace..... Va.

16. Informant..... sister: Mrs. Annie Nesley  
 Address..... 1321 Corcoran St., N.W., Wash., D.C.

17. burial Date thereof.....  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Va.

18. Funeral director..... W. Ernest Jarvis *B. N. J.*  
 Address..... 1432 U St., N.W., Wash., D.C.

19. 2-6- 19 48 Mary C. Patterson Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6 February 19 48, at 1:10 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
13 January 19 48 to 6 February 19 48  
 and that I last saw him alive on 6 February 19 48

Immediate cause of death.....  
Carcinoma, Naso-pharynx DURATION indef.

Due to.....  
 Due to.....

Other conditions..... Metastases to Liver and  
Spine; Bronchopneumonia, LLL; indef.  
Hypertensive heart disease (Include pregnancy within 3 months of death)

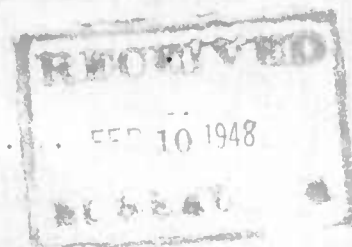
Major findings of operations.....  
 Date of op. ....

Autopsy results..... Confirmed above.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?  
A. E. Marland, Jr.  
 23. SIGNATURE..... A. E. MARLAND, Jr., Lt. JG MC USN  
 M. D. or other

Address..... USNH Bethesda, Md. Date signed 2-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sandy Spring  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Preston Rivers

## 3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

January 3, 1945

8. AGE:

Years

Months

Days

If less than one day

3110

hrs.

min.

9. Birthplace

Washington, D.C.  
(Town, county, and state)

10. Usual occupation

child

11. Industry or business \_\_\_\_\_

FATHER

12. Name

Robert A. Rivers

13. Birthplace

Cheraw, South Carolina

MOTHER

14. Maiden name

Julia May Pearce

15. Birthplace

Galax, Virginia

16. Informant

Hospital records

Address \_\_\_\_\_

17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Feb. 14, 1948  
(month) (day) (year)

Cemetery or crematory

Coleville Cemetery

Location

Coleville, Md.

18. Funeral director

Warner E. Pumphrey

Address

Silver Spring, Md.

19.

Feb. 17, 1948  
(Date rec'd by registrar)

1948

Gertrude B. Lawler  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date stated; that I attended deceased from

Diff. med. Exam case 19\_\_\_\_ to 19\_\_\_\_  
 and that I last saw him alive on 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

DURATION

Due to

Due to

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Frank J. Bruchant M.D.

M. D. or other

Address Washington, Md. Date signed 2-13-48

RECEIVED

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 414

## 1. PLACE OF DEATH:

County Montgomery CountyCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 daysHospital, institution, or street address where death occurred:  
Washington Sanitarium & HospitalHow long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. CountyCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. 1466 Columbia Rd. N.W.  
(If rural, give LOCATION) ✓

2(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Mary Ruth Rockfield

## 3. (b) Social Security Number

## 4. Sex

Fe Hebrew

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Divorced

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 2, 1899

## 8. AGE:

Years

Months

Days

If less than one day

48 2

hrs. min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

Sales Lady

## 11. Industry or business

## FATHER

## 12. Name

Solomon Berlin

## 13. Birthplace

Russia

## MOTHER

## 14. Maiden name

Florence Goldman

## 15. Birthplace

Russia

## 16. Informant

Address Washington San. & Hosp.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof Feb 3, 1948  
(month) (day) (year)

## Cemetery or crematory

Charles E. Green & Sons

## Location

Washington D.C.

## 18. Funeral director

Address Goldberg Funeral Home  
4217 - 9th St. NW Wash.

## 19.

(Date rec'd by registrar)

19 48Joseph M. Schaeffer  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 25, 1948, to Feb. 1, 1948  
and that I last saw him alive on Feb. 1, 1948Immediate cause of death terminal  
disseminated pneumonia

## DURATION

2 wks.

Due to

Infect. - Pneumonia

Due to

basal

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Paul E. Egan

M. D. or other

Address 4847-200 Ave. Date signed Feb. 48

RECEIVED  
FEB 3 1948  
BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01847

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Bethesda, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
National Naval Medical Center, Bethesda, Md.  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County PG  
 City or town Cottage City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3927 37 th Pl.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Spanish-American

## 3. (a) FULL NAME

Ryan, John Augustus

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 5.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mrs. Pauline Ryan  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) August 29, 1873  
 8. AGE: 74 Years 5 Months 23 Days If less than one day  
 ..... hrs. .... min.

9. Birthplace Penna.  
 (Town, county, and state)  
 10. Usual occupation Retired Civil Service  
 11. Industry or business  
 FATHER  
 12. Name John A. Ryan  
 13. Birthplace New York  
 MOTHER  
 14. Maiden name Catherine Goulden  
 15. Birthplace Penna

16. Informant wife: Mrs. Pauline Ryan  
 Address 3827 37th Pl., Cottage City, Md.  
 17. Burial 2-25-48  
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Va.  
 18. Funeral director W.W. Chambers Co. pjk  
 Address 517 11th S. E. Washington, D.C.  
 19. 2-21 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 February 19 48 at 5:50A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
18 February 19 48 to 21 Feb. 19 48  
 and that I last saw him in alive on 21 February 19 48  
 Immediate cause of death Cerebral Hemorrhage  
 DURATION 12 hrs.?  
 Due to Generalized Arteriosclerosis Indef.  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Henry R. Cooper  
Henry R. Cooper  
 Address US Naval Hospital, Bethesda, Md.  
US Naval Hospital, Bethesda, Md.

**RECEIVED**

FEB 26 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Suburban Hosp.  
8600 Old George Town Rd., Bethesda Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1909 Stratton Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

William F. Ryder

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 4, 1901

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

46

4

30

hrs.

min.

9. Birthplace

Washington D.C.  
 (Town, county, and state)

10. Usual occupation

CLERK - RETIRED

11. Industry or business

U.S. GOVERNMENT

FATHER

12. Name

W. F. Ryder

13. Birthplace

Washington D.C.

MOTHER

14. Maiden name

Mary E. Barry

15. Birthplace

Washington D.C.

16. Informant

Mrs. Nell Chancey (sister)

Address

1909 STRATTON RD - SILVER SPRING

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

FEB - 6 - 1948  
 (month) (day) (year)

Cemetery or crematory

MT OLIVET

Location

WASHINGTON D.C.

18. Funeral director

James E. Pumphrey, Inc.

Address

SILVER SPRING - MD.

19.

(Date rec'd by registrar)

2/7/48

Thos E. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-3, 1948 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dep med exam case 19...  
 and that I last saw him alive on 19...

Immediate cause of death

Phos. fatal poisoning  
accidental

DURATION

2 days

Due to

Due to

Other conditions

Acute alcoholism

4 day

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-1-48

Where did injury occur? Silver Spring Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Mens of injury Phos. fatal poisoning Injured at work? no

23. SIGNATURE Frank J. Burchart M.D.

Dep med exam M. D. or other

Address Washington Md Date signed 2-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County Montgomery County  
 City or town 7th & Park Blvd.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 days 15 hrs 40 min  
 Hospital, institution, or street address where death occurred:  
Washington San & Hospital, Takoma Park  
 How long in hospital or institution? 19 days 15 hrs 40 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1841 Columbia Rd. N.W. apt 4  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Katherine Shoemaker

## 3. (b) Social Security Number

4. Sex

F.

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Blair Shoemaker

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age \_\_\_\_\_ years

1878

8. AGE:

69

4

7

9

hrs.

10

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

Federal Housing

FATHER

12. Name

Roland F. Crome

13. Birthplace

New York City

MOTHER

14. Maiden name

Lillian Kreame

15. Birthplace

Washington D.C.

16. Informant

Hospital Record

Address

Washington San &amp; Hosp. Tr.

17.

BURIAL (Burial, cremation, or removal. Which?)

Date thereof

2 17 48 (month) (day) (year)

Cemetery or crematory

GLENWOOD

Location

WASHINGTON - D.C.

18. Funeral director

The S.H. Hines Co.

Address

2901-14TH ST. N.W.

19.

Feb 14 1948 (Date rec'd by registrar)

1948

Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2-14-

19 48 at 10:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/6/48

19 48

to 2/14

19 48

and that I last saw her alive on

2/14

19 48

Immediate cause of death

Acute diffuse peritonitis - (chemically)

DURATION

7 days

Due to

Biliary fistula -

8 days

Due to

Cholecysto-duodeno-fistula

years?

Other conditions

Ch. diffuse hepatitis -

years. 10

(Include pregnancy within 3 months of death)

Major findings of operations

Cholecysto-duodeno-fistula -

Date of op.

2/4/48

Autopsy results

as above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

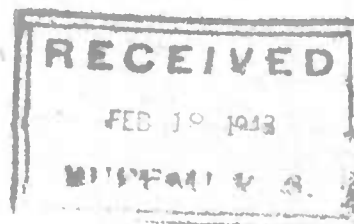
23. SIGNATURE

John A. Brownshyn - M.D.

M.D. or other

Address

Takoma Park - Md. signed 2/14/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Montgomery County  
 City or town Farmers Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since 2-3-48  
 Hospital, institution, or street address where death occurred:  
Wash. San. & Hospital  
 How long in hospital or institution? Since 2-3-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. D.C. County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4806 Byers St. S.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John William Sichert Jr

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Ann Catherine Sichert  
 6.(c) If alive, give age 48 years  
 7. Birth date of deceased (mo., day, yr.) 6-7-98  
 8. AGE: Years 49 Months 9 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
 (Town, county, and state)

10. Usual occupation Baker

11. Industry or business \_\_\_\_\_

FATHER 12. Name John W. Sichert

13. Birthplace Germany

MOTHER 14. Maiden name Punkertstein

15. Birthplace Germany

16. Informant Ann Catherine Sichert

Address 4806 Byers St S.E.

17. Burial \_\_\_\_\_ Date thereof Feb 20-1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland Maryland

18. Funeral director Arthur E. Summers Jr

Address 2007- Nichols Ave S.E.

19. Feb 18 19 48  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 19 48 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 19 48 to Feb. 17 19 48  
 and that I last saw him alive on Feb. 17 19 48

Immediate cause of death Carcinoma of Colon with metastases to regional nodes & liver  
 DURATION 6 mo. +

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations as above

Date of op. 2-13-48

Autopsy results Fat necrosis due to obstructed duct

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Hermon D. Slatt, M.D.

700 Sumner St. M. D. or other Alert, Va.

Address \_\_\_\_\_ Date signed 2-18-48

RECEIVED

FEB 20 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01851

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

8401 Connecticut Avenue,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8401 Connecticut Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3.(a) FULL NAME

Mary T. Slevin

## 3.(b) Social Security Number

None

|                         |                                  |   |
|-------------------------|----------------------------------|---|
| 4. Sex<br><u>Female</u> | 5. Color or race<br><u>White</u> | 6.(a) Single, married, widowed, or divorced<br><u>Widowed</u> |
|-------------------------|----------------------------------|---|

6.(b) Name of husband or wife Eugene F. Slevin

|   |   |
|---|---|
| 7. Birth date of deceased (mo., day, yr.)<br><u>October 2, 1878</u> | 6.(c) If alive, give age<br>..... years |
|---|---|

|                            |                    |                   |  |
|----------------------------|--------------------|-------------------|--|
| 8. AGE: Years<br><u>69</u> | Months<br><u>4</u> | Days<br><u>15</u> | If less than one day<br>..... hrs. .... min. |
|----------------------------|--------------------|-------------------|--|

9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Charles Callahan13. Birthplace Ireland14. Maiden name Bridget Boyle15. Birthplace Ireland16. Informant Mrs. Bridget CallahanAddress Chevy Chase, Maryland17. Burial Date thereof Feb. 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's Church CemeteryLocation Forest Glen, Maryland18. Funeral director Wm. Haden HumphreyAddress Bethesda, Maryland19. 2/16 78  
(Date rec'd by registrar) Registrar Mrs. E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 19 48, at 5:30am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/10 19 47 to 2/13 19 48  
and that I last saw him alive on Feb 13 19 48Immediate cause of death Carcinoma sigmoid DURATION 1 yearDue to —Due to —Other conditions Generalized abdominal  
Carcinomatous  
(Include pregnancy within 3 months of death)Major findings of operations —Date of op. —Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Emile M. Millerand M. D. or otherAddress Harford Hospital Date signed 2/14/48

RECEIVED

FEB 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: Montgomery  
 County.....  
 City or town..... Takoma Park Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
135 Kaplan Ave  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
D. C. County.....  
 City or town..... 7115 9th St. N. W.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Washington D. C.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

James Albert Spicer

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife..... Virginia H. Spicer  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) May 14, 1844  
 8. AGE: Years 103 Months Days If less than one day  
 hrs. min.

9. Birthplace..... Rappahanock Va.  
 (Town, county, and state)  
None  
 10. Usual occupation.....  
 11. Industry or business.....  
 12. Name..... Samuel S. Spicer  
 13. Birthplace..... Culpepper Va.  
 14. Maiden name..... Nancy Teabill  
 15. Birthplace..... Va.

16. Informant..... Elliott Spicer  
 Address..... 7115 9th. St. N. W.  
 17. Burial..... 2/12/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Walkers Chapel  
 Location..... Madison Co. Va.  
 18. Funeral director..... Deal Funeral Home  
 Address..... 4812 Georgia Ave. N. W. D. C.  
 19. Feb 10 1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 at 9:25 p m  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1947 to Feb 9 1948  
 and that I last saw him alive on Feb 9 1948

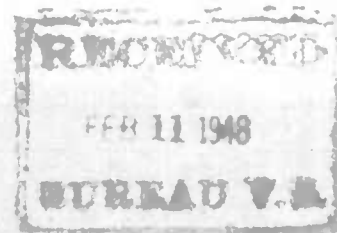
Immediate cause of death..... acute cardiac failure  
 Due to..... Arterio Sclerotic Heart Disease  
 Due to..... Generalized Arterio Sclerosis  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Neau H. Harding M D  
 Address..... 113 Carroll St NW  
Wash DC  
 Date signed 2-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01853

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

7414 Wisconsin Avenue,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County FairfaxCity or town Fairfax, Virginia  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3712 Valley Drive Park,

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Hugh E. Spittal

## 3. (b) Social Security Number

161-18-7760

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Gladys Dentler Spittal6. (c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) August 24, 19088. AGE: Years ✓38 Months 38 Days 5 If less than one day 19 hrs. min.9. Birthplace Dravosburg, Pennsylvania  
(Town, county, and state)10. Usual occupation Employee-Army Map Service11. Industry or business None12. Name James Spittal13. Birthplace Unknown14. Maiden name Ruth N. Davies15. Birthplace Wales16. Informant Gladys D. Spittal (wife)Address Park Fairfax, Virginia17. Burial Date thereof Feb. 17, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Biglerville, CemeteryLocation Pennsylvania18. Funeral director Wm. Ransom RumphreyAddress Bethesda, Maryland19. 2/15/48 Wm E Jones

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th, 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DEP. MED. EXAM. CASE: DiedCoronary occlusion Suddenly

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D.

Dep. Med. Exam. M. D. or other

Address Gaithersburg, Md. Date signed 2/14/48

RECEIVED  
FEB 21 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MONTGOMERY  
 City or town SILVER SPRING, MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 HRS.  
 Hospital, institution, or street address where death occurred:  
WASHINGTON SANITARIUM  
 How long in hospital or institution? 1 1/2 HRS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County MONTGOMERY  
 City or town SILVER SPRING  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8715 CAMERON ST., APT 3  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BABY STRICKLAND

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE  
 6. (b) Name of husband or wife NONE  
 7. Birth date of deceased (mo., day, yr.) 23 FEB. 1948  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
2 hrs. 6 min.

9. Birthplace SILVER SPRING, MARYLAND  
 (Town, county, and state)

10. Usual occupation INFANT (NEWBORN)

## 11. Industry or business

12. Name HAROLD WADE STRICKLAND

13. Birthplace ELLEN SMITH STRICKLAND

14. Maiden name ELLEN SMITH STRICKLAND

15. Birthplace TAKOMA PARK, MARYLAND

16. Informant HAROLD WADE STRICKLAND

Address 8715 CAMERON ST. APT 3

17. Cremation Date thereof 2/24/48  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Washington Sanitarium

Location Takoma Park, Md.

18. Funeral director Washington Sanitarium

Address Takoma Park, Md.

19. Feb 24 1948  
 (Date rec'd by registry)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 FEB. 1948, at 1:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 FEB. 1948 to 23 FEB. 1948

and that I last saw him alive on 23 FEB. 1948

Immediate cause of death ATALECTASIS,

prematurity

Due to PREMATURITY

Due to SPONTANEOUS BIRTH AT

2 1/2 WKS GESTATION

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE L. Marshall Cuvillier, M.D.  
 M.D. or other \_\_\_\_\_

Address 8648 BEAR & 1A AVE. Date signed 24 FEB. 48

01854

159



RECEIVED

FEB 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01855216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Sudden death  
 Hospital, institution, or street address where death occurred:  
109 Leland Street,  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 109 Leland Street,  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

Fred Wallace Thurston3. (b) Social Security Number  
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Noble Thurston  
 6. (c) If alive, give age 69 years  
 7. Birth date of deceased (mo., day, yr.) June 13, 1881  
 8. AGE: Years 66 Months 66 Days 8 If less than one day hrs. min.

9. Birthplace Iowa  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business None

12. Name Unknown-Thurston  
 13. Birthplace Iowa  
 14. Maiden name Carrie Unknown  
 15. Birthplace Iowa

16. Informant Mrs. E. W. Thurston  
 Address Chevy Chase, Maryland

17. Cremation Date thereof Feb. 21, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill Crematory

Location Washington, D. C.  
 18. Funeral director WM Rauden Pumpfrey  
 Address Bethesda, Maryland

19. Feb 21 19 48  
 (Date rec'd by registrar) Registrar Wm E Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 19 48 at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
 and that I last saw him alive on 19

Immediate cause of death  
DEP. MED. EXAM. CASE

## DURATION

Died  
Suddenly

Due to Coronary occlusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Frank J. Prochaska M.D.Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 2/21/48

RECEIVED

FEB 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01856

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months  
 Hospital, institution, or street address where death occurred:  
215 Wellesburg Dr, Silver Spring  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County Orange  
 City or town Unionville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Estelle Remy Lorsch

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
 B. (b) Name of husband or wife Joseph Lorsch  
 B. (c) If alive, give age deat years  
 7. Birth date of deceased (mo., day, yr.) 17 Feb. 1962  
 8. AGE: Years 85 Months 11 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westtown New York  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name Unknown  
 13. Birthplace "  
 14. Maiden name "  
 15. Birthplace "

16. Informant Mrs F. Strader  
 Address 215 Wellesburg Dr, Silver Spring  
 17. Shipment + Burial Date thereof Feb. 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Unionville  
 Location Unionville, Orange Co. N.Y.  
 18. Funeral director Warner E. Pumphrey  
 Address Silver Spring, Md. S.C.F.  
 19. Feb 10 19 48 Joseph W. Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Feb 19 48 at 2 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Feb 19 48 to 10 Feb 19 48  
 and that I last saw him alive on 7 Feb 19 48

Immediate cause of death Cardiac decompensation

## DURATION

304 yrs.

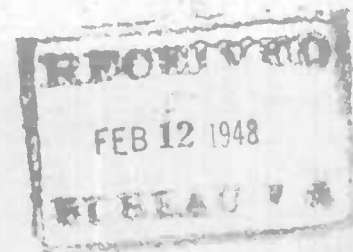
Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Serious  
Cerebrovascular  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE William D. And MD  
 M. D. or other \_\_\_\_\_  
 Address Silver Spring Md Date signed 10 Feb 48



Evidence for change  
of age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01857

FILE No. G 114 MAR 16 1948

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 2-3-48  
Hospital, institution, or street address where death occurred: SUBURBAN HOSP  
8600 Old Georgetown Rd Bethesda Md.

How long in hospital or institution? since 2-3-48

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8902 Old Bladensburg Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mr. Carroll wee Turner

### 3. (b) Social Security Number

214-03-9437

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Helen Turner

7. Birth date of deceased (mo., day, yr.) Nov 17<sup>TH</sup> 1899 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 48 Months 0 Days 14 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montgomery Co., Md.  
(Town, county, and state)

10. Usual occupation Maintenance Supt.

11. Industry or business Preston Wire Constr Co.

12. Name Frank Turner

13. Birthplace Montgomery Co.

14. Maiden name Liza Clark

15. Birthplace Montgomery Co.

16. Informant MRS HELEN E TURNER

Address 8902 Old Bladensburg Rd.

17. BURIAL Date thereof Feb. 9<sup>TH</sup> 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington D.C.

18. Funeral director Warner & Pumphrey

Address Silver Spring - Md

19. 2/8 48 Wm E Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 19 48 at 5<sup>00</sup> A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post 19 47 to 6 Feb 19 48

and that I last saw him alive on 5 Feb 19 48

Immediate cause of death Pneumonia, lobar, cause undetermined

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Tuberculosis of lungs

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

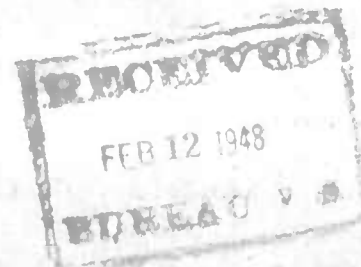
23. SIGNATURE William D. Aul, M.D. M. D. or other

Address Silver Spring, Md. Date signed 6 Feb 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2-16

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? few minutes

Hospital, institution, or street address where death occurred:

5100 Moorland Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State S.C. CountyCity or town Spartanburg  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2.(a) If veteran, name war  ✓

## 3. (a) FULL NAME

Theodore Roosevelt Wallace

## 3. (b) Social Security Number

## 4. Sex

m

## 5. Color or race

col

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Bertha Wallace

## 7. Birth date of

deceased (mo., day, yr.)

Feb 22, 19036. (c) If alive, give age 37 years

## 8. AGE:

Years

Months

Days

If less than one day

44hrs. min.

## 9. Birthplace

Spartanburg, S. Carolina  
(Town, county and state)

## 10. Usual occupation

Caretaker

## 11. Industry or business

MOTHER FATHER

## 12. Name

Maude Wallace

## 13. Birthplace

Union S. Carolina

## 14. Maiden name

Lula Frye

## 15. Birthplace

## 16. Informant

Cornelius Wallace (Bro.)

## Address

814 - Oakwood Blvd, Chicago, Ill

## 17.

Shipped  
(Burial, cremation, or removal. Which?)

## Date thereof

Feb 9, 1948  
(month) (day) (year)

## Cemetery or crematory

## Location

Chicago, Illing's

## 18. Funeral director

Robert L. Snowden

## Address

Rocky Creek

## 19.

2/9  
(Date rec'd by registrar)19 48Wm E. Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 48 at 11:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med. Exam case  
and that I last saw him alive on 19

Immediate cause of death

Hemorrhage due to gun shot wound in abdomen

Due to

Homicide

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide homicide Date of 2-15-48Where did injury occur? Bethesda Monty Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) private homeMeans of injury fatal shot Injured at work? no23. SIGNATURE Frank J. Brochart M.D.  
Dep. med. Exam M. D. or otherAddress Spartanburg Md Date signed 2-6-48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

01859

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Seneca  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 37 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Rural Seneca  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route 2 in Seneca  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

HARRIET ANN WARD

## 3. (b) Social Security Number

None

4. Sex F. 5. Color or race col. 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife Charles Ward  
 7. Birth date of deceased (mo., day, yr.) 1861  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Panthersville, Montgomery, Md.  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name John Conley

13. Birthplace Maryland U.S.A.

14. Maiden name Maria Johnson

15. Birthplace Maryland U.S.A.

16. Informant Marta Beckwith (daughter)

Address Seneca, Md.

17. Burial Date thereof 2/15/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Seneca

Location Seneca, Md.

18. Funeral director Reynolds & Davis

Address Poolsville, Md.

19. Feb 14 48 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 February, 1948 at 9:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 February, 1948 to 11 Feb. 1948  
 and that I last saw her alive on 11 Feb. 1948

Immediate cause of death congestive heart failure  
 DURATION 3 days

Due to pneumonia, Lobar, Bilateral 10 days

Due to debility + extreme old age 25 yrs. (4/4/23)

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations none

Autopsy results none Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John S. Fawcett M.D.

M. D. or other \_\_\_\_\_

Address P.O. Royal, Md. Date signed 12 Feb. 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs.

Hospital, institution, or street address where death occurred:

9311 Montgomery Avenue,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9311 Montgomery Avenue,

(If rural, give LOCATION)

2. (a) If veteran, name war None

## 3. (a) FULL NAME

Betty B. Weadon

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Dr. F. Mason Weadon6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) November 28, 19068. AGE: Years 41 Months 2 Days 8 If less than one day hrs. min.9. Birthplace Philadelphia, Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name C. Howard Baily13. Birthplace Pennsylvania14. Maiden name Unknown15. Birthplace Pennsylvania16. Informant Dr. F. Mason WeadonAddress Chevy Chase 15, Maryland17. Cremation Date thereof Feb. 7th, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CrematoryLocation Washington, D. C.18. Funeral director Wm. E. JonesAddress Bethesda, Maryland19. 2/7 19 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 19 48 at 10:55AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 19 47 to Feb 6 19 48 and that I last saw him alive on Feb 6 19 48Immediate cause of death Cirrhosis of LiverDue to unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bradley D. Hodgkins MD M. D. or otherAddress 313 W. Bradley Lane Date signed 2/6/48

01860

1248



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

01861

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 months, 26 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 8 months, 26 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 310 D St., N.E.  
 (If rural give LOCATION)  
WWI  
 2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

WILLIAMS, Primiano (n)

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Anna Williams  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 18, 1890  
 8. AGE: Years 57 Months 9 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Italy  
 (Town, county, and state)  
 10. Usual occupation Pattern Maker  
 11. Industry or business U. S. Navy yard  
 12. Name WILLIAMS, ? dec.  
 13. Birthplace Italy  
 14. Maiden name unknown  
 15. Birthplace unknown

18. Informant wife; Mrs. Anna Williams  
 Address 310 D St., N.E., Wash., D.C.

17. burial Date thereof 2-26-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Wash., D.C.

18. Funeral director Lee Funeral Home  
 Address Penn. Ave., S.E., Wash., D.C.  
mem. C. Patterson  
 19. 2-24 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 February 48 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
5-27- 1947 to 2-23- 1948  
 and that I last saw him alive on Feb. 23 1948

Immediate cause of death pneumonia, bronchitis  
 DURATION ± 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Carcinomatosis, due to  
Carcinoma of Colon  
 (Include pregnancy within 9 months of death) 3 years

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy result Confined above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. F. HARRISON, Lt. MC USN M. D. or other

USNM Bethesda, Md. Address \_\_\_\_\_ Date signed 2-24-48

RECEIVED

FEB 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 3 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 315 Elm St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Sp. Am.

## 3. (a) FULL NAME

YOUNG, George Andrew

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced widowed  
 8. AGE: Years 73 Months 3 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 6.(c) If alive, give age \_\_\_\_\_ years

## B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 4, 1874

9. Birthplace Missouri  
 (Town, county, and state)

10. Usual occupation Ret. Stewart

## 11. Industry or business

FATHER 12. Name Andrew Young dec. Mo.  
 13. Birthplace Mo.  
 MOTHER 14. Maiden name ARABELL, Addie dec. Mo.  
 15. Birthplace Mo.

16. Informant niece: Mrs. Tulip Peck  
 Address 315 Elm St., N.W., Wash., D.C.

17. burial Date thereof Feb. 24, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director Robert G. McGuire Op Lee  
 Address 1820 9th St., N.W., Wash., D.C.

19. 2-19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1948 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 January 1948 to 19 February 1948 and that I last saw him alive on 19 February 1948

Immediate cause of death Chronic Nephritis

Due to Hypertensive Heart Disease

Due to Bronchopneumonia and Arteriosclerosis, Generalized  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. Marland, Jr. Lt. JG MC USN  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 2-19-48



